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Social Research

Project Report

ALBERTA CO-ORDINATED HOME CARE PROGRAM

- ENTRY STUDY

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INTRODUCTION

This report presents the results of our examination of the present entry criteria for Alberta's Co-ordinated Home Care Program (CHCP).

These criteria were adopted at the time the program was initiated, in April, 1978. They reflect a deliberate decision to give the program a "medical" orientation. That is, entry is restricted to those requiring either nursing or a rehabilitation service. Entry is denied to those who only require a social support service.

This decision reflected, among other considerations, the limited availability of support services. During Phase I of the implementation plan, these services have grown and as the program prepares to enter Phase II, it is in a position to meet a heavier demand for non-medical services. As well, segments of the public and some professional groups have urged the adoption of more inclusive criteria.

Phase I will conclude on March 31, 1982. This is an appropriate time to reconsider the rules of entry. Alberta has a choice between making no change to the entry criteria or adopting one of a number of possible changes. The decision must be made on the basis of both the service implications and the feasibility of implementing a particular change.

The first need is for a list of reasonable options. In developing these, actual experience with the use of other entry rules is relevant. Four provinces (Ontario, Manitoba, Saskatchewan, and British Columbia) were visited to gather information about their entry criteria and program operations. All readily available data on home care admissions and service utilization were also collected.

The quality and quantity of available data varied from province to province. Manitoba, Alberta, and to a lesser extent, Ontario were able to provide sufficient information to allow detailed comparisons. In Saskatchewan and British Columbia, only limited information was available.

The information collected was used to analyze the effects of different entry criteria, to develop feasible options for a change to Alberta's program and to project the likely impacts. Options were evaluated from the perspective of their feasibility and their consistency with basic policy objectives. Estimates of the consequences of each option are compared to estimates of what will likely occur if no changes are made. These estimates, however, reflect the limitations of the data on which they are based. They should therefore be interpreted as indications of the likely direction of change, rather than as highly accurate projections of magnitude.

II

HIGHLIGHTS

A. VISITS TO OTHER PROVINCES

As the first phase of this study, our research team visited four other provinces offering co-ordinated home care programs:

- British Columbia
- Saskatchewan
- Manitoba
- Ontario

Using a semi-structured interview schedule, we interviewed senior home care program officials in each province. (The interview schedule is presented in Appendix A). The purpose of the interviews was to collect the following information:

- Descriptions of the program design, operation and administration.
- Readily available quantitative information about home care recipients (admission rates, age of recipients, service utilization patterns, treatment outcomes).
- Background information on factors in the province affecting home care services (influence of other services, demographic characteristics, other pertinent factors).

B. DESCRIPTION OF HOME CARE PROGRAMS IN OTHER PROVINCES

1. Ontario

The Ministry of Health operates two home care programs: an Acute Care program and a Chronic Care program.

- The Acute Care program is available province-wide. It is administered by 30 local Boards of Health, four local V.O.N., three general hospitals and a non-profit organization. Applicants to the program require a medical referral and must need at least one professional service (nursing, physiotherapy, occupational or speech therapy).

- The Chronic Care program is available in seven districts at present. It is administered by the same local authorities as the Acute Care program. The entry criteria include the same criteria as the Acute program. In addition, a person may be admitted to prevent or delay deterioration in a medical condition or to prevent transfer to a higher level of care. This program will be expanded in 1982.

The Ministry of Community and Social Services operates the Homemakers and Nurses Services program. The emphasis of the service is on social development and the avoidance of dependence on social assistance. Recipients of the program pay for service on the basis of their assessed financial need.

2. Manitoba

Manitoba's Home Care program is provided through the Department of Health and Community Service's seven regional offices and five district health centres. In Winnipeg, short-term care is the responsibility of the V.O.N. The program offers a full range of services:

- Household Maintenance
- Personal Care and Hygiene
- Health Maintenance Services
- Health Treatment

Eligibility for the program hinges on the need for service to maintain or prevent deterioration of the functional ability required for living at home. Service may also be provided as relief for families and to those waiting institutional placement. Patients discharged from acute care are also eligible. Eligibility is demonstrated through an assessment of health, social functioning and environmental supports.

3. Saskatchewan

The program is operated under the auspices of the Department of Social Services. It delivers four services - nursing, meals, homemaking and home maintenance - through a network of 45 local home care programs. The entry criteria are focused on avoiding institutional placement. The key is the existence of a condition (medical or non-medical) which if left to itself would force an institutional placement. Eligibility is determined through a functional assessment.

4. British Columbia

The Ministry of Health operates three home care programs.

- The Long Term Care program (LTC) was set up to meet the needs of persons who, because of health-related problems, are unable to live independently. It provides both care in residential facilities and home care.

- The Home Care component of the LTC program has a distinct character and two main divisions.

  - The Non-hospital Replacement program provides nursing, physiotherapy, medical equipment, meals, homemaking and other services for the ill or handicapped who require professional care in order to remain safely at home.

  - The Hospital Replacement program provides the same services for those who would otherwise require an acute care bed.

- The Homemaker Program provides housekeeping, assistance with daily living, handymen, nutrition, shopping and laundry services. It is primarily for the elderly at risk of institutional placement.

Both the Long Term Care Program and the Home Care program require referral by a physician and a need for at least one professional service (nursing, physiotherapy or occupational therapy). For the Homemaker program, the main entry criterion is inability to function independently because of a health-related problem.

The Ministry of Human Resources operates a Family Support Homemaker Service. Its objective is to provide temporary support and relief to families and individuals under stress. The program is administrated through MHR regional offices. It is basically an adjunct to the social assistance program.

5. Continuum of Entry Criteria

The five provinces represent a continuum of home care entry criteria.

- Saskatchewan is the most open and closest to the pure "social entry".

- Manitoba is somewhat less open. It does however allow entry for persons whose ability to live independently is at risk whether or not from a specific medical condition; and who require either medical or non-medical services.

- Ontario, British Columbia and Alberta have the most restrictive criteria. Either an applicant must have a medical referral and require a medical service (Ontario's AHC and CHC; B.C.'s Long Term Care and Home Care; Alberta's CHCP) or they must be in financial need (Ontario's Homemakers and Nurses Service program, B.C.'s Family Support Homemaker Service, Alberta's Family and Community Support Services).

C. INTER-PROVINCIAL COMPARISONS OF ENTRY RULES AND REGULATIONS

Quantitative information from the five provinces was used to analyze the effect of differing entry criteria on eight key dimensions of home care:

- admission rate
- rejection rate
- referral patterns
- age of entrants
- sex and marital status of entrants
- diagnostic and treatment classifications
- type of service and length of stay
- status at discharge

The comparisons are based on data from:

- Ontario's AHC and CHC programs
- Manitoba's Continuing Care program
- Saskatchewan's District Home Care program
- Alberta's CHCP
- B.C.'s Home Care and Homemakers programs

The "social assistance" programs in Ontario, Alberta and B.C. are not included in the analysis.

Complete data on each of the eight dimensions was not available in most of the provinces. Comparisons in many cases are limited to Manitoba and Alberta.

1. Admission Rates

Relative to provincial total populations and to the populations over 65, Alberta is presently admitting fewer people than the other provinces. Alberta's admission rate is closest to Manitoba's and Saskatchewan's. Ontario and B.C. have the highest admission rates.

2. Rejection Rates

Alberta rejects the highest proportion of total applications. Its rejection rate of 26% contrasts with 14% in Ontario and 7% in Manitoba.

3. Referral Patterns

In Alberta and Manitoba, hospital and physician referrals account for the majority of referrals. In Ontario, the two major sources for referral to the chronic care program are acute care hospitals and community agencies.

4. Age Factors

In all provinces, more than 50% of home care recipients are over 65. Alberta ranks in the middle on this dimension. Ontario and B.C., with specialized acute care programs, have the smallest proportion of recipients over 65. Manitoba and Saskatchewan have the highest proportion. Alberta's position in the middle is consistent with the absence of either a strictly acute care or a social entry provision.

5. Sex and Marital Status

In Alberta and Manitoba, recipients are predominantly female (64.6% and 66.4%) in the two provinces. Alberta, however, serves relatively more single people and relatively fewer widowed. The lower age of Alberta recipients probably accounts for this difference.

6. Diagnosis and Treatment

The distribution of home care recipients by diagnostic category is very similar in Manitoba and Alberta. Cardiovascular and musculo-skeletal problems are the most frequent diagnoses. In Ontario, neoplasms and injuries are the most frequent diagnoses.

In terms of treatment goal, a higher proportion of those admitted in Alberta have a treatable medical condition than in Manitoba. A higher pro-

portion of recipients in Manitoba have a condition that is expected to deteriorate. Further, in Manitoba, 71% of those admitted with a deteriorating condition are over 65. In Alberta, only 54% are over 65.

7. Type of Service and Length of Stay

No comparative data on this dimension was available from other provinces.

8. Discharge

Alberta discharges 31% of its patients to their own homes, with no further treatment required. This compares with 59% for Ontario's Acute Care program, 25% for Ontario's Chronic Care program and 36% for Manitoba's program. In Manitoba, however, a higher proportion of patients are discharged into nursing homes or acute care hospitals. Manitoba lacks the community care facilities available in Alberta.

9. Summary

The following points have emerged from the analysis:

- The B.C./Ontario and Manitoba/Saskatchewan programs seem to cluster together on a number of program dimensions. This includes age and entry rate.

- Alberta at present seems to fall somewhere between these poles on the dimensions observed; but closer to the support service pole and seems to have an active caseload with similarities to that of Manitoba.

- The main differences between Manitoba and Alberta have to do with a higher presence in Manitoba of persons who cannot be rehabilitated; and the much larger percentage of entrants who receive support services such as homemaking or homehelp assistance.

The factors which seem to be associated with entry criteria variations, and which may therefore be particularly sensitive to entry changes are as follows:

- admission rate
- rejection rate
- age of entrants

- referral patterns
- length of stay
- type of service received
- status at discharge

The factors which on the basis of the evidence available show no strong evidence of being associated with entry criteria are these:

- sex
- marital status
- diagnostic category

- Medical entry criteria tend to produce a caseload which is relatively
  - younger
  - has greater rehabilitation potential
  - less likely to receive support services
  - discharged more quickly
  - higher in effective demand

- Entry criteria stressing functional capacity tend to produce a caseload which is relatively:
  - older
  - has less rehabilitation potential
  - more likely to receive support services
  - discharged more slowly
  - lower in effective demand.

- On balance, the Alberta caseload more closely resembles the latter than the former.

D. ENTRY OPTIONS

We identified five main options for change to existing CHCP entry criteria.

1. No Change

Leave present entry criteria and resource obligations unchanged.

2. Leave Existing Medical Entry Criteria (ME_1) Intact, Increase the Local Availability of Therapy and Support Services

LHA's could be requested to provide therapy services. Additional support services would be provided.

3. Create Separate Acute and Chronic Systems

CHCP entry could be limited to those with a medical condition which is treatable and remediable in the short term. Chronic care and social assistance needs would be met by a parallel system.

4. Retain the Requirement for a Medical Condition but Establish Additional Entry Services (ME_2) Providing Social Supports

Admission would be opened to those having a specific medical condition that does not require treatment by a physician or health practitioner. Entry services would be expanded to include homemaker and/or other support services.

5. Adopt a "Social Entry"

The need for a specific medical condition would be removed. Emphasis would be placed on providing services to avoid institutional placement and keeping persons in their homes.

E. ASSESSMENT OF ENTRY OPTIONS

1. Preliminary Assessment

After a preliminary assessment, we eliminated two options from further consideration: "Separate Chronic/Acute Care Systems" and "Social Entry".

- Separate Chronic/Acute Care Systems would require a complete organizational re-structuring of CHCP and the F.C.S.S. program. It creates potential problems for care planning and service delivery co-ordination. Program overlap and duplication could result, as could intensified competition for resources.

- Social Entry is too discontinuous with the current operating ethos of the LHA's. More importantly it would pose excessive sup-

port service manpower demands at a time of current unmet needs of those already in the system.

2. Detailed Evaluation

The remaining three options were assessed in terms of their potential impact on:

- admissions
- active caseload
- service mix and intensity
- staffing
- costs

Exhibit II-I compares the three main entry options.

F. RECOMMENDATIONS

Seven recommendations are made.

1. ME_1 should be modified.
2. Change should be in the direction of admitting persons with no need for active medical treatment.
3. ME_2 should be adopted.

4. Implementation planning should include:

   - An intensive support staff recruitment and retention program.
   - Increased use of auxiliary staff.
   - Development of a scored functional assessment as a mandatory part of entry.

5. Homemaking should be the first support service added to the entry list. Homehelp, personal care and possibly meals could be considered at a later date.

6. Public announcements of entry changes should await development of support service delivery capacity.

7. Consideration could be given to further modifying ME_1 by replacing the requirement for a physician's certification with the functional assessment results, for those applicants having no active medical care need.

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EXHIBIT II - 1 Comparison of the three main entry options

Options	Admissions to March 31 1985	Active Caseload to March 31/85	Service Mix & Intensity	Staffing needs overall	Costs
1. ME_1 - no change	Range of 13,000 to 22,000	Growth estimated to reach 10,350	Incremental growth of demand for support services. No basic change in intensity.	Will grow in direct proportion to caseload increase. Support staff needs will grow 10-15% faster.	As per current estimates
2. a) All entry services mandatory b) Increase support services	a) 100 more per year. b) Depending on timing and extent of service added, could reach 16,000 - 26,000.	Substantial increase in support services will increase average length of stay and caseload will grow at a rate above admissions.	Depends on whether emphasis placed on support services for areas now unserved.	Will be a function of level of funding	Policy changes will modify current estimates.
3. ME_2	An estimated 6,500 more entrants.	Will grow at a rate .75 faster than admissions from ME_2 entrants.	Substantial shift in mix factor. Nursing: -4.5 Homemaker: +7.5 Homehelp: +8 Pers. Carer +2.5 Service demand per patient will increase.	Will require an estimated 24 nurses, 330 homemakers, 200 homehelp aides 8 - 10 physio. 4 - 6 Occ. Ther. 48 personal care aides.	Additional cost per full year - estimated at up to $5.6 million

III

POLICY PERSPECTIVES ON HOME CARE

A. THE ALBERTA CO-ORDINATED HOME CARE PROGRAM

The Alberta Co-ordinated Home Care Program (CHCP) provides in-home nursing, rehabilitative and support services to eligible residents of Alberta. Established in 1978, the program is funded by the provincial government and delivered under the direction of Local Health Authorities (LHAs). The province establishes basic criteria for the program in terms of eligibility and service provision requirements. The local Management Committees have considerable autonomy to establish more restrictive entrance criteria and to decide which additional services will be provided.

B. ALBERTA'S PRESENT CRITERIA - A DESCRIPTION

The existing entry criteria are set out in Section 7 of regulations under The Health Unit Act (except for Edmonton and Calgary). There are six of these. Applicants must satisfy each one.

1. "Entrants must be registered under the Alberta Health Care Insurance Plan."

This has brought a few criticisms from time to time from applicants not legally resident in Alberta but it is not a serious problem. If these increase, the solution is inter-provincial reciprocity agreements, not the scrapping of the requirements.

2. "The cost of providing home care services to a person will not exceed the cost of providing the equivalent level of care in a health care facility."

This provision is sound in intent. Its proper interpretation is perhaps a bit more uncertain than need be because no time period is mentioned; and "cost" is undefined as to means or timing of the calculation. The real issue is whether present entry procedures should identify the probable costs before entry occurs. In current practice application of this criterion probably means removing people from the program once the actual cost of service is known, perhaps by arranging a suitable institutional transfer. (The value of entry criteria which legitimize the need to make such forecasts will be discussed

below). The related issue of what weight, if any, should be given to individual or family preference for entering home care over institutional care is probably best left to local home care administrators and individual circumstances.

3. "Due to a person's condition, the program is the most suitable method of providing health services."

Again, the intent is sound. The question is whether the current means for determining the "most suitable method" are fully satisfactory. This is an administrative matter, exceeding the terms of this study.

4. "A physician certifies that, in his opinion, a person under his care is in need of a home care nursing or rehabilitation therapy service."

The presence of a physician in the picture is sound so long as the requirement does not lessen the opportunity for a full assessment of support service needs and does not replace whatever entry judgements program staff must make.

5. "A co-ordinator certifies that the applicant's home is suitable for the provision of care."

Again, a very sound provision which is standard with most North American home care programs whether or not they have "medical entry". The direction in which change options lie is in giving greater entry weight to this criterion and further developing the means for its assessment.

6. "A co-ordinator certifies that in his opinion a person requires home care nursing or rehabilitation therapy service."

This is the central criterion shaping the character of the present entry rules. The primary choice to be made is whether or not to change it. All change options will ultimately be measured against their effect on this single element.

C. CHANGES TO ENTRY CRITERIA

Consideration of changes to the entry criteria is focussed on two of the existing regulations - Criteria 4 and Criteria 6. These two criteria define the present program as a medical entry model. For shorthand purposes, Criteria 4 and 6 will be designated as ME_1 (Medical Entry One).

Analytically displayed, ME_1 can be said to look like this:

- The applicant must have a medical condition.
- This condition's existence must be observed by a physician.
- The condition must be treatable at home, i.e. the applicant is likely to benefit in some way from therapeutic intervention, in his residence.
- The indicated treatment must be one which can be provided by a nurse or therapist.

When considering changes to ME_1, the effect of modifying one or more of these components must be assessed. Such an assessment should be made within a framework reflecting:

- the function of entry criteria
- the policy objectives of home care
- the issues involved in making entry choices
- predictions of likely effects based on the experience of other home care programs using different entry models.

D. THE FUNCTION OF ENTRY CRITERIA

Home care is not a generic service but a delivery mechanism. It is the antithesis of institutional care.

As a concept it is extremely elastic. Documents reviewed in the course of this report have spoken of some 30 additional services recommended for inclusion in the Alberta home care program. Furthermore, home care utilization is not naturally limited by sex or, in any absolute way, by age. Short of death, long-term institutionalization, or full rehabilitation there are no natural points at which to permanently withdraw care once delivery begins. The possibility of over-dependence and the excessive utilization of services by recipients is continual.

All social programs require entry provisions. But home care, by its nature, requires criteria with above-average control and boundary potential.

- The first function of entry criteria is to give applied expression to the main programmatic objectives. They are the operating link between policy and practice; the first and most crucial step in the conversion of intent into achievement.

- Secondly, they sum up and display in concrete form more or less exactly who the program is for. This is vital in creating public awareness of who should approach the program and under what circumstances.

- Third, they are the main rationing device - a key mechanism for limiting public claims on the limited resources available.

- Fourth, they define the administrative domain of the program in relation to other social and health services.

In essence, entry criteria are the operational expression of the policy objectives of a program. Judgements about the most appropriate form of entry criteria are therefore best made by clearly understanding primary policy objectives.

E. POLICY OBJECTIVES OF HOME CARE

Interpretations of Alberta's Home Care experience to date -- and reactions to proposed changes -- are affected by one's sense of the program's ultimate purpose. There are several possibilities:

1. Substitution.

Home care can be seen as a lower-cost alternative to other, and especially to institutional, forms of health care. Which kinds of care you see home care replacing (e.g. acute hospital, extended care, nursing home) and how you rank these are crucial matters. Sub-categories are the avoidance of initial admissions and the reduction of the length of stay once placed.

2. Community Residence.

Here, the opportunity to continue living at home, perhaps with family and friends, is the core value. Numerous other social and ethical objectives are involved. This perspective can emphasize inter-generational family life or the need to avoid rural depopulation by resisting the pressure on senior citizens to move from rural areas and hamlets into centres where care is more likely available.

3. Functional Capacity.

The ability of individuals to care for themselves and handle the chores of daily living can be preserved and restored; or the rate of loss retarded. Self-care through enhanced health education and nutrition are related values.

4. Social Service System Development.

The extension of the social service delivery network into the home is seen as offering opportunities for improved co-ordination of a range of human services. It is also thought to be a way of responding to changes in the nature of family life and to the increasing number of elderly living alone.

5. Resource Optimization.

Home care is thought by some to be more cost efficient than other forms of social service delivery. Capital, equipment and maintenance costs are relatively small. Training costs and salaries for non-professional support services are modest. Outcomes are said to be measurable.

6. Family Crisis Assistance.

This usually involves services to overcome some impediment to the ability of family members to care for disabled or non-adult members. The temporary absence of care-providers or inadequate parenting or homemaking are typical causes of the need for this service.

7. Public Support.

Home care is a highly visible and accepted means of care delivery, especially when targeted on the elderly. In practice, there are few negative side-effects undercutting the positive reaction to the program's image. In particular, it is seen as consistent with traditional forms of neighborly caring.

Before deciding on entry criteria for Phase II, it would be useful to identify the policy perspectives from which this judgement will be made. A list of ultimate objectives to be maximized -- possibly longer or shorter than the one above -- ranked in order of importance could help to locate the "right" decision.

F. FIRST ORDER ENTRY CHOICES

Once the Department has established the perspective from which the entry decision for Phase II will be taken, addressing certain first order entry choices becomes crucial. Final decisions can be made later. But approaching this report with some notion of the range of preferred options will aid in narrowing the choices.

For the moment we will by-pass the question of who the program is for and take up certain major control parameters used in other home care programs. While these issues have probably already been discussed by CHCP managers for Phase I, reconsideration in the light of three years experience is advised.

1. Functional Limits. Over what range of physical and mental impairments should the program accept applicants? This is a policy choice having major resource implications. Should the program concentrate on those with light to moderate impairments? Care for such persons is less expensive per patient and quick pay-offs more likely. Or should entry emphasize those with heavier impairments, i.e. those more likely to otherwise require institutionalization? One's position on the substitution issue will help to answer this point.

Obviously, home care entry should be denied to those with full or zero functional ability alike. But what are the acceptable boundaries?

Entry Issue: Do you wish to define any explicit functional limits on those accepted into the program? This is increasingly a possible way of approaching the question of entry control because of the advancement of reliable tools for the measurement of functional capacity.

2. Duration. The next issue in logical sequence is the setting of a maximum limit on the acceptable duration of impairment. The familiar acute/chronic dichotomy is one way of structuring this matter. In operational terms, it is closely related to but not identical with short term/long term treatment dichotomies.

Entry Issue: Do you wish to limit entry to those with conditions which are likely to be treatable over a designated period? If so, of what length?

One's position on the value of sustaining community or family residence, relative to the importance of hospital substitution, is significant here. For by and large, the maintenance of persons in their own homes is a longer-term undertaking; especially for the elderly.

3. Cost. Having addressed the question of the acceptable duration of the impairing condition, we come to whether entry should be limited by prior estimates of the level, type and cost of service. This can be judged either in relation to some fixed ceiling or as to whether the desired care outcome can be attained with less expense by some other medium of service.

Entry Issue: Are the total cost per case and the related manpower demands to be forecast before individual entry decisions; or only made after?

One's attitude toward system-wide resource optimization will affect the response to this.

4. Marginal Utility. In assessing needs and allocating resources, who should have the higher claim -- new applicants or existing patients? As long as resources exceed demand this is a point without practical meaning. But in the presence of manpower shortages (either because staff or the dollars to hire them aren't available) this is a trade-off that must be made. What is of greater marginal value - a fifth hour of occupational therapy a week to a multiple scleroris victim; or one hour of occupational therapy a week for a new applicant with arthritis?

Entry Issue: Is the entry decision to be affected by considerations of marginal utility? Put less theoretically, on what basis does the program balance the additional service needs of those already in the program against the potential needs of new applicants?

One's attitude toward this will be conditioned in part by the value one places on developing public support for the program by providing service to more people; even if it means providing less service to some already enrolled.

Conclusions. For Phase I none of these criteria have been in effect as formal entry or demand control criteria in Alberta. This has resulted in the primary burden of effective entry control being borne by a single element, the so-called medical entry provision. And this in turn has highlighted the effect of this single criterion in the minds of observers and the interested public.

It is probably preferable for program managers to make explicit policy choices about whether to impose major operating limits; rather than have them emerge in different ways on an ad hoc basis according to local preference or the availability of resources.

G. SECOND ORDER ENTRY CHOICES

A typology of entry systems would include those with:

1. A Single Criterion.

This could be a formal requirement of almost any sort: eligibility for health insurance coverage, age, place of residence, citizenship, referral point, ability to pay for the service. The advantage is the absence of any need to weigh the importance of one criterion against others applicants may or may not have met.

Such on/off systems are easy and quick to administer; but are highly arbitrary and offer little control to a manager in need of grounds for the rapid expansion/constriction of entry in response to resource or policy environment pressures, or unanticipated surges of demand.

2. Multiple criteria in which all are formally equal.

This has an array of formal conditions applicants must satisfy. Its advantage is that there is no need to weigh the merits of different criteria; but its weakness is the possibility that, although formally equal, the criteria are in fact not of equal importance for selecting suitable patients. Yet even the least crucial, if violated, can itself veto admission.

3. Multiple criteria in which the elements are stratified.

Here there are certain explicit conditions such as a suitable living arrangement one must first meet. If satisfied, the applicant then faces subsidiary barriers, some proportion of which he must also satisfy to gain entry. Once in, however, he has the same status as any other entrant. The advantage is a certain flexibility, or standing possibility for exceptions, which designers know of and find acceptable. The disadvantage is the increased probability that such exceptions will occur.

4. Multiple criteria producing conditional entry.

If you satisfy all the prevailing core criteria, entry is granted. Satisfying only some results in entry being conditional upon present or future demands on the system and the strengths of the claims of others. One could be let in and kept in conditionally; that is, as long as resources made it possible. For example, a person awaiting placement in a nursing home could be given support service until the resources used were required to allow discharge from hospital of a new entrant. This approach can be used in

smoothing out the peaks and valleys of demand for homemakers and other support service providers; or in using staff during a dip in priority admissions.

Disadvantages are the time for administrative execution and the negative reaction of persons discharged from care when others needs are dominant.

5. Professional assessments.

Some systems do not spell out any formal external criteria to which applicants must conform. Rather, they rely on the otherwise unstructured determination of need by those with professional training. Such systems are flexible but may make subjective and highly variable judgements. The use of "check-list" admissions forms are common with this type. Such entry systems are difficult to change as modifications can be quickly seen as a challenge to professional prerogatives or competence.

6. Standardized written assessments.

Here external or "circumstance" criteria like age or residence may or may not count for much. Entry swings on the result of standardized assessment of functional, social, health or economic status as measured by a written and usually scored instrument. Assessors may or may not be professionals. In either event, the aim is to make the assessment as objective and rigorous as possible. The advantages are the degree of knowledge and control policy-makers have over the entry process. The fidelity of actual admission decisions to policy objectives can be more easily verified. And by changing the written instruments the operational effect can be modified. The main disadvantage is in restricting the scope of professional judgement, especially in complex cases; and in imposing what may be seen as a cumbersome procedure on both staff and applicants.

Combinations, of course, are possible. Alberta's type combines the multiple criteria - all equal (Type 2) with the professional appraisals (Type 5). This combination has been widely used in the initial stages of a number of programs. Increasingly, North American home care programs are adopting some type of formalized assessment instrument keyed to the measurement of specific functional states,

H. EFFECT OF DIFFERENT ENTRY MODELS

The entry choices outlined in the preceeding sections must be evaluated against a set of standards. Successful entry criteria can be characterized in the following way:

- Congruent with the fundamental policy objectives and the amount of funding available for the achievement of these objectives.
- Congruent with the services actually provided throughout the delivery system. That is, the entry filter must pass only those whose needs can in fact be subsequently met by the care available.
- Congruent with basic public notions of equity and common sense.
- Unambiguous enough to be easily understood by applicants and consistently applied by administrators.
- Flexible enough to permit field administrators latitude for interpretation.
- Able to equally accommodate the different natural and dominant groupings into which applicants are divided (e.g. the aged and non-aged).
- Free of cultural, geographic or socio-economic bias.
- Free from unrealistic assumptions about how people will in fact behave when using the program.
- Capable of identifying a unique target population needing a service not duplicated by other programs.
- Suited to the particular delivery system and the skill levels and orientations of those who apply them.

To assess the entry options against these standards, predictions about actual effects of each model are required. These predictions can be derived from examination of the experience of home care programs using entry criteria different from Alberta's. Succeeding chapters describe the study we undertook to collect such information from other jurisdictions and analyze Alberta's options, using the information obtained.

IV

HOME CARE IN OTHER JURISDICTIONS

A. VISITS TO OTHER JURISDICTIONS

1. Expected constraints on comparability.

This study was designed to use the experience of other jurisdictions to develop projections of the likely impacts of a change to Alberta's entry criteria. The four other provinces offer home care programs based on models that differ to a greater or lesser degree from Alberta's. Their home care programs can serve as comparison groups in a "natural" experiment.

Ideally, the study would have involved systematic sampling, yielding a clean data set, comparable from jurisdiction to jurisdiction. The time-frame of this study, however, precluded such an approach. Instead, we had to rely on existing provincial data.

We anticipated that record-keeping would vary from province to province. The type of data collected, and the frequency of reporting would differ.

Even when the data were superficially similar, we expected that there would be definitional differences that must be understood before the provincial data could be confidently compared. For example, all provinces may have a case type called "musculo-skeletal disorders" but use somewhat different definitions when actually categorizing patients.

Service category labels may also mask significant differences in actual service provided. One unit of "homemaker services" in one jurisdiction may involve more hours of service than in another. Services called "homemaker" in one province may include service described as "nursing" or "home help" in another.

We also expected that the data collected would reflect the influence of many factors in addition to entry criteria. The availability of services, the maturity of the program, service delivery mechanisms, the presence of other home care-type programs, and demographic factors will all exert an influence on observed rates and patterns of service consumption. Because of these considerations, it was important to collect detailed background information about the context and operation of each provincial program.

2. Development of interview schedule.

The first task in the study was to develop a schedule for semi-structured interviews to be conducted in each jurisdiction. Through discussions with Alberta Home Care directors, we developed an interview outline designed to collect both the pertinent quantitative data and the background information required for interpretation. The interview protocol, presented in Appendix A, was approved by the research steering committee.

3. Visits to other jurisdictions.

Staff of the Co-ordinated Home Care Program provided us with an initial list of contacts and a telephone introduction to primary contacts in each jurisdiction. Our research staff identified other respondents through discussions with Home Care representatives in each province.

Our staff visited each province to complete the interview protocol. Provincial contacts are presented in Exhibit IV - 1. Succeeding sections of this chapter provide summary descriptions of each provincial program as background to a comparative assessment of the effect of entry criteria. Detailed field reports appear in Appendix B.

B. ONTARIO

1. Description of programs operated by Ministry of Health

The Ministry of Health is responsible for two major home care programs under the Health Insurance Act, 1972. The entire province is covered by 38 active treatment home care programs. These are administered by 30 local Boards of Health, the VON (four programs), local general hospitals (three programs) and a non-profit corporation with a nine-man Board of Directors responsible for the Metro Toronto program. The Metro Toronto program is by far the largest with a budget in excess of $10 million and 150 full-time staff.

Ontario operates two separate programs. The Acute Home Care (AHC) program is the older and larger. It is designed for short-term care; and in fact in 1979 - 80 the average stay was 39 days.

The first AHC programs began regular operation in 1964. Twenty-five more began operating between November 1970 and July 1974.

EXHIBIT IV - 1. Provincial Contacts

British Columbia

Phil Scott	Director of Home Care and Long Term Care Ministry of Health.
Anne Geddes	Project Researcher Ministry of Health.
Rudy Denys	Deputy Manager Family Support Services Section Ministry of Human Resources.
Gloria Guttman	Simon Fraser University

Saskatchewan

Lloyd Beaumont	District Development Officer Home Care Division Saskatchewan Social Services
Helene Donahue	Director Continuing Care Division Home Care Branch Saskatchewan Social Services.
Steven Lewis	Access Consulting Limit (Evaluation of Sask. Home Care)
Neil Deninger	District Manager Home Care District No. 45
Dr. Duncan Robertson	Head Geriatric assessment unit University Hospital Saskatoon
Bob Fish	Director of Health Unit Saskatoon Local Health Authority
Cecile Alexander	Nursing Director Psychiatric Home Care Program Saskatoon

EXHIBIT IV - 1 cont'd

Manitoba

Enid Thompson	Director of Continuing Care
Margaret Barber	Program Administrator Continuing Care Program
Evelyn Shapiro	Assistant Professor Department of Social and Preventative Medicine University of Manitoba.

Ontario

Mr. Richard Stilwell	Program Manager Home Care Program Advisory Branch Ministry of Health.
Mr. Robert Youtz	Program Manager Home Care Federal-Provincial Relations Branch Ministry of Community & Social Services
Ms. Rowney	Manager

Seven of the 38 offer chronic care programs as well. The first three started on October 1, 1975. This is the Chronic Home Care (CHC) program. The Ministry of Health began this program in 1975. It is provided by the same local delivery agencies. A number of other districts now providing only acute care are planning to add chronic care. The intent is to create a CHC program covering the entire province. This is based on a policy decision by the Ministry of Health to move in this direction. The aim is also to bring AHC and CHC closer together as functional entities. This is planned to begin in 1982. First, however, additional chronic care programs will be set up.

Metro Toronto plans to begin running a chronic care program April 1, 1982. Metro Toronto has experienced growth averaging 15 - 20% per year. Over time, cases have become more complex. Admissions average 1,600 patients a month. Length of stay averages 38 days and is increasing. This latter experience is perhaps typical for other AHC programs and is one reason why the Ministry of Health decided to introduce chronic care province-wide.

AHC is for persons likely to recover from a medical condition over the short term. When progress toward the medical goal identified at time of intake "is no longer apparent", discharge to a more appropriate form of care occurs. This includes possible transfer to Chronic Home Care. Rehabilitation is not a prime objective. Rather, the main purposes are the reduction of hospital admissions; the shortening of such placements when they do occur; and the provision of care at home when this is in the interest of the patient.

2. Entry criteria for Ministry of Health programs.

AHC entry is not tightly defined and the program does not have a specific target group beyond that already given, e.g. age, disability type. There are no age or income restrictions on admissions; nor is there any limit concerning degree of illness. Assessments are done locally, usually by public health nurses. These normally take place after a written application from a physician. No assessments take place without this request.

The application form (D-1) is basically a check list covering the standard items (See Appendix B for a copy). No formal functional assessment is required.

Applicants must need at least one professional service (nursing, physiotherapy, occupation or speech therapy). Need for homemaking does not satisfy this criterion. In this sense the Ontario entry requirements are identical to Alberta's ME_1.

CHC entry criteria are identical to those for acute care, including a physician's referral and need for at least one professional medical service. However, in addition to the goal of short-term recovery from a medical condition (as with AHC) a person may also be admitted to prevent or delay deterioration in a medical condition or to prevent transfer to a higher level of care, including nursing care. The average length of stay in CHC is 116 days. This is the essential difference between AHC & CHC.

Both programs provide the same services. These are nursing, physiotherapy, occupational and speech therapy. Homemaking is also available. However, the ceiling on AHC homemaking of the equivalent of 10 eight hour visits during an enrollment is increased for CHC to an 80 hour maximum in the first month and a 40 hour maximum in the second and each subsequent month of care. Some local variation in the interpretation of entry criteria is evident. But this occurs within fairly specific boundaries. Apparently, some service is provided in institutional settings.

3. Description of program offered by Community and Social Services.

The Ministry of Community and Social Services is responsible for The Homemakers and Nurses Services program, run by the same local agencies that deliver the full range of COMSOC's municipal social services. The program operates under the authority of The Homemakers and Nurses Services Act - 1950. Local programs are the responsibility of both local governments and Indian bands. Actual services are provided by a variety of private and public agencies. Nursing comes from the Red Cross or the VON, homemaking from Visiting Homemaker Associations. Meals are served by church or other volunteer groups. Commercial outlets provide meals in Toronto.

The emphasis of the service is on helping persons to remain in their own home, to help families cope with the care of children when a parent is absent, or where the homemaking is inadequate. Program goals are consistent with social work goals; that is, with social development and the avoidance of dependence on social assistance. As such, the entry criteria go well beyond ME_1 but stop short of general social entry because of the emphasis on avoidance of social assistance. As such, this program is in some ways similar to other "welfare services" as defined by the Canada Assistance Plan (1966). The CAP concept of financial need, and Ontario Family Benefits Act regulations limits on assets underline this element.

For applicants over 60, social assistance-like eligibility criteria are less crucial. Here, need for the service in connection with the aim of independent living becomes more significant. As you would expect, the range of social support services increases. Such things as friendly visiting, security checks, transportation, information and referral, shopping, letter writing and financial management assistance are provided. There is a considerable amount of local variation in eligibility, services provided, charges and limits on income.

No data on admissions or utilization are available and no figures for entry into this program are used in comparing inter-provincial admissions. This program would appear to be outside the mainstream of home care development in Ontario. However, a joint task force has recently been struck to address the relationship between the programs. Both Health and COMSOC offer homemaking and nursing services; and service providers work for both departments.

But in general, because of differing eligibility criteria, the two programs are complimentary. Only about 3% of the cases are thought to be eligible for both programs. One objective of the current negotiations is to remove this small overlap and make the two programs mutually exclusive. A second concern is to remove gaps in service that may presently exist.

C. MANITOBA

1. Description of program.

The centrally co-ordinated program began in September, 1974. At that time the responsible agency was the Department of Health and Social Development. At the end of the 1970's the department was divided into separate health and community services ministries. Home care (or continuing care as it is known in Manitoba) remains responsible to both departments.

The service is provided in rural Manitoba through the department's seven regional health and community service offices and five somewhat more independent district health centres (or clinics). In Winnipeg, long-term care is provided through the regional offices. Short-term care in Winnipeg (under 60 days) is the responsibility of the VON. This is a concession to the existence of the VON in Winnipeg prior to 1974. With this exception, delivery is through the government's "single unit delivery system" for community health and social services. The only limit on the cost of care is the requirement that it not exceed the cost of alternative institutional placement. Specific exceptions are possible.

Exhibit IV - 2 shows the main services and providers in Manitoba.

EXHIBIT IV-2. Manitoba services and providers

Household Maintenance	Personnel Providing Service
Meal Preparation	Homemakers
Cleaning	
Laundry	
Personal Care and Hygiene	
Assistance in:	
Bathing	
Grooming	Homemaker and/or Aide/Orderly
Feeding	
Dressing	
Health Maintenance Services	
Health Teaching	Public Health Nurse/Registered Nurse
Surveillance	Public Health Nurse/Registered Nurse/ Licensed Practical Nurse
Drug Care	Registered Nurse/ Licensed Practical Nurse/Homemaker
Diet Care	Homemaker/Home helper
Physical Exercises	Physiotherapist/Homemaker Aide
Activation	Occupation Therapist/Homemaker Aide
Supervision/Social Relief	Sitter Attendant
Foot Care	Registered Nurse/Licensed Practical Nurse
Health Treatment	
Treatment Procedures	Medical Doctor/Public Health Nurse/ Registered Nurse
Drug Therapy	Public Health Nurse/Registered Nurse
Diet Therapy	Home Economist/Public Health Nurse
Physiotherapy	Physiotherapist
Speech Therapy	Speech Therapist/Public Health Nurse
Occupational Therapy	Occupational Therapist

Service providers are both departmental personnel and private individuals employed (usually part-time) by the regional offices or health centres. Civil servants include: public health nurses, social workers and mental health workers. Services are purchased from : RN's, LPN's, Homemakers, Home Care Aides/Orderlies and speech therapists. Contract staff make up the bulk of care providers. In a typical month in 1980, the contract staff included;

- 1,682 part-time homemakers
- 103 registered nurses
- 76 licensed practical nurses
- 136 home care attendants.

2. Entry criteria in Manitoba.

The service philospohy stresses the provision of service to those who need it in order to continue living at home. There are no age or length-of-stay limits. In particular, eligibility hinges on the need for service to maintain or prevent deterioration of the functional ability required for living at home. Service may also be provided as relief for family or other care providers; and to those awaiting placement in an institutional bed. Patients discharged from acute care are also eligible.

A physician's referral is not required; and by itself is not sufficient to gain entry. There is no requirement related to the need for any specific service.

The essential entry criterion is the demonstration through an assessment of health, social functioning and environmental supports, that a) one is at risk of institutional placement and b) this can be reduced or overcome by the provision of one or more of the services listed above. The functional assessment uses a locally-developed instrument for which its developers claim substantial proven validity and reliability (copy contained in Appendix B).

Seven out of 10 persons admitted have more than one health problem and less than 5% do not have a specific medical condition. Seventy-seven percent of new admissions require nursing in the first month. But for long-term care recipients this declines to 35% who continue receiving nursing. There is a parallel increase in the use of support services.

There is no legislative base for the program and none is planned.

The point is strongly made by staff that service can be provided only to the extent made possible by manpower availability. In practice, this means a limit on professional services. Some of the pressure has been eased by increasingly using LPN's to supervise personal care, freeing up nurses for more complex cases. Specialized professional services are generally available in adequate numbers.

Assessments are normally done by a team headed by a designated case co-ordinator. These are always either registered nurses or social workers. The nurses have degrees in public health nursing or hold the baccalaureate degree.

Most of the social workers are M.S.W.'s. The co-ordinator will be selected according to the background which most satisfies the particular case. As the patients' needs change, so can the discipline of the co-ordinator. This means after starting out with a nurse, chronic care cases could be subsequently transferred to a social worker. The co-ordinator decides what services are required, for how long and in what volume. Because the delivery agencies are field units of the department, and key supervisory staff are civil servants under centralized direction, there is very little local variation in eligibility criteria. A central patient registry in Winnipeg helps to maintain effective central supervision of operations.

Manitoba places great stress on periodic patient re-assessments and the re-drawing of care plans. This can and does result in the termination of service.

In essence, entry is controlled more by a process than by the application of any one criterion; as is discharge. Within a fairly well defined and centrally monitored structure, there is substantial room for professional judgement.

Enrollment is and has been under control. Expansion in 1974 did not create the demand predicted at the time. It was expected that the caseload would increase to 14,000 within two years (or 1.35% of the total population). In fact, by December 1980 it had reached only 9,961. An extensive review of the program and its entry criteria by the Management Committee of Cabinet in 1975 found no evidence of unnecessary admissions or excessive utilization of services.

The provincial average enrollment is 6.2% of those over 65 on home care in Manitoba at any one time.

Fiscal restraint in recent years has put some pressure on the availability of regional staff. As a result, some local nurses have proposed limiting admission to those needing nursing services, along the lines of ME_1. This idea is not supported at senior policy levels of the department.

In effect, the Manitoba program is both acute and chronic; long and short-term. Entry is gained if one has a problem (medical or non-medical) threatening continued residence at home. Both medical and non-medical services are provided extensively. In practice, most persons admitted have a medical condition but the program is geared to meet the social needs arising from this condition.

In appraising the feasibility of Manitoba-style criteria, two central points must be borne in mind.

- Regional supervisors and service delivery staff have a direct reporting relationship through regional directors to an assistant deputy minister who is also responsible for the home care head office. This ensures a continuing and direct central program influence over field operators.

- The program has not been hesitant to prioritize applications on the basis of need; to tailor the amount of service delivery to both degrees of functional need and staff availability; and to discharge patients who should be in nursing homes.

D. SASKATCHEWAN

1. Description of program.

Intention to establish a new, integrated home care delivery structure was announced by the Minister of Social Services in April, 1978. Prior to that time separate home care programs had been operated by the Departments of Health and Social Services. The Health programs offered primarily nursing and therapies through local clinics, health regions and hospitals. Much of the hospital care was acute. Social services funded some 120 separate community services ranging from homemaking and meals to home maintenance, transportation and friendly visiting. These were offered by Homemaker Societies, senior citizen clubs and associations and civic organizations.

Under the new plan, all home care funding was transferred to Social Services, effective April 1, 1979. The only direct service provision by civil servants was by public health nurses primarily as part of a generalized caseload. Gradually, this is being discontinued as the districts gain the capacity to provide home nursing with their own staff.

The new program is to deliver four services -- nursing, meals, homemaking, and home maintenance -- through a network of 45 local home care societies. Each society has its own designated geographic district. These range in total population from 7,000 to 175,000. Each society has its own Board elected by members of the district home care society. Membership in the society is open to all adults. Funding is on the basis of an annual per capita grant from the Department. For 1980 - 81 this was $12.30 per head. There are plans to adjust this to the percentage of those in the district's population who are over 65; where this exceeds the provincial average.

Boards are free to offer additional services from an approved list if funding is available after meeting the demand for the four primary services.

Boards can a) deliver all services by hiring staff, b) contract with existing agencies, or c) some combination thereof. The net result, however, must be the availability of all four services throughout the district.

There is no charge for nursing. A user fee is applicable to meals, homemaking and home maintenance.

Over 40 Boards are now in existence; and in excess of 20 are providing services. In many cases, existing community home care organizations have merged; and in a few cases closed down.

2. Entry criteria in Saskatchewan.

The service is primarily designed to avoid institutional placements, especially placement in nursing homes. Saskatchewan has one of the highest percentages of residents over 65 in Canada, and a very high incidence of nursing home placement. The number of persons in Saskatchewan in nursing homes is roughly equal to the number in such homes in Alberta, which has over twice the total population of Saskatchewan (but only about 40% more senior citizens).

There is no limit by age or duration of stay. As with programs in other provinces, the cost of care cannot exceed the cost of alternative institutional placement for more than 30 days. No physician's referral is required for entry. However, a physician must order any medical treatment carried out by home care nurses.

No particular service is required to satisfy entry requirements. One can gain admission, for example, for meals or home maintenance.

The key is the existence of a condition which, if left to itself would force an institutional placement. The condition may be either medical or non-medical. In this sense, the Manitoba and Saskatchewan programs are similar. In practice, the number of Saskatchewan entrants having no specific medical condition would be much higher than in Manitoba.

As with Manitoba, Saskatchewan uses a functional assessment instrument to determine if the applicant is at risk of institutional placement. This is a modified version of the Duke University OARS instrument (copy of original attached in Appendix B).

Assessments are done by local assessors hired by the home care district Boards. They represent many different backgrounds. Unlike Manitoba, no professional qualifications are required. Training in the use of the OARS is a necessity. The same instrument can be used to assess need for nursing home placements.

Some boards have complained about the lengths of the assessment documents (With a skilled assessor it is said to need at most 45 minutes). Consideration is being given to revisions. Although OARS was developed for use by both professionals and non-professionals, it is not clear how successful the new program will be in getting local non-professional administrators to cooperate with the more demanding requirement for a functional entry assessment.

Starting in early 1979, Boards began opening. Priority was given to those areas with the least existing services, which usually meant rural districts with small populations. For this reason, it is too early to observe the mature level of demand from the more populated areas.

One significant factor is that although eligibility for the new home care program is wider than any other province's, it is considerably narrower than that previously used by many of the local home care agencies in Saskatchewan. Many were providing a very wide range of services on demand to any person over 65.

Because the new system will offer province-wide service for all four services, more effective demand will be felt, especially in rural areas. So the new program has one major factor limiting demand over the previous level; and another expanding actual availability to a narrower clientele. At this point, it is not known what the cumulative effect of these will be.

Saskatchewan has the most non-restrictive entry provisions of the four provinces surveyed.

E. BRITISH COLUMBIA

Depending on how you count them, British Columbia can be said to have five home care programs, four of which are the responsibility of the Ministry of Health.

1. Programs operated by Ministry of Health

a) Long Term Care Program. This was set up in 1978 to meet the needs of persons who, because of health-related problems are unable to live independently. In response, it provides both care in residential facilities and home care. Available figures do not clearly distinguish between these two types of care.

This is the main continuum of care program in British Columbia. Its facilities include 17 adult day care centres, three geriatric assessment and treatment centres and Community Care facilities. It also provides homemakers, handyman and meal services. Because of the non-availability of figures allowing for an accurate identification of the proportion of total care which is equivalent to CHCP, and because of the existence of other programs more closely resembling CHCP, this program (LTC) is not included in any of the further analysis. The effect is to understate -- to an unknown extent -- the actual level of home care services provided in the province.

b) Home Care. This is a component of the overall LTC program, but has a distinct character and two main divisions:

i) The Non-hospital Replacement (NHR) program started in 1940, is the oldest program surveyed in any of the four provinces. It exists to provide nursing, physiotherapy, medical equipment, meals, homemaking and other services. It is for ill or handicapped persons who require professional care in order to remain safely in their own homes. The alternative for these people would be a non-acute care institutional placement. The care can be long-term and many persons with chronic conditions are in this programs.

ii) The Hospital Replacement program was set up in 1971. It provides exactly the same services as the NHR, but is for those who would otherwise require an acute care bed; or is for those who, with the program, can be discharged from an acute care bed. The majority of these people are acutely ill. Being the newer program it is not yet available in all the province (coverage is about 85%). Persons remain in this category as long as the service

they are receiving is regarded as replacing acute care hospital days. All services received are paid for by the Ministry of Health.

The program is regionally administered through health district offices. Each district has a home care administrator who is an experienced public health nurse. Physio-and occupational therapy, where available, are provided by district staff. Homemaking is contracted for through the local homemaker agency. Meals are provided by a variety of local arrangements.

c) Homemaker Program. The Health Ministry also operates a "homemaker" program, begun on January 1, 1978. This is the main provincial homemaker program. It is primarily for the elderly who are at risk of institutional placement. It actually provides housekeeping, assistance with ADL, handymen, nutrition, shopping and laundry services.

2. Entry criteria for Ministry of Health programs

For both the Long Term Care Program and the Home Care Program, entry requires referral by a physician and a need for at least one professional service other than care by a physician, that is: nursing, physiotherapy, or occupational therapy. As in Ontario, these two requirements are identical to ME$_1$. These two programs resemble the acute and chronic care programs in Ontario. Other entry provisions are the ones standard to most home care programs. Assessments are usually made by nurses. An application of the check-list variety is used. No standard functional assessment is required.

The main entry criterion for the Homemaker Program is inability to cope or function independently because of a health-related problem. Assessments are done by nurses or social workers.

Much of the service actually goes to those enrolled in the LTC program; so again it is not possible to isolate a unique caseload. Therefore, for comparative purposes, none of the recipients of this care were counted in caseload figures. It has both its own more or less exclusive clients and also provides services to other programs. This program is responsible for provincial homemaker staff training programs, development of homemaker services, the negotiation of fees to be paid to individual homemaker societies and the establishment and monitoring of homemaker standards.

3. Program operated by Ministry of Human Resources

The Ministry of Human Resources operates a Family Support Homemaker Service. Its objective is to provide temporary support and relief to individuals

or families under stress. In particular homemakers are provided to:

- support the normal family routine when the parent or parents are temporarily unable to do so;
- prevent family breakdown;
- improve child care and household management skills;
- provide temporary relief to parents of handicapped children;
- support adult retarded in community living;
- provide temporary assistance to individuals in crisis.

The program is arranged for and administered through MHR regional offices. Almost all services are purchased from non-profit agencies. Those individuals eligible for LTC (aged, chronically ill and disabled) are referred to that other program.

This program is subsidiary to the general homemaker program operated by the Ministry of Health. It provides service to an estimated 850 families a month. Basically it is an adjunct to the social assistance program. In a situation similar to that in Ontario, with the growth of the Health Ministry's programs it has declined in importance.

4. Entry criteria for Human Resources Program

As with the program operated by Ontario's Community and Social Services, this one is largely for potential or actual social assistance recipients. Assessments are done by social workers.

F. NATIONAL HOME CARE TRENDS

1. Models of Home Care Organization

The four provinces can be said to represent three different models of organization.

a) Separate acute, chronic and "welfare services" programs, with different eligibility criteria for the latter.

Acute care programs include Ontario's AHC and British Columbia's Hospital Replacement programs.

Chronic care programs are represented by Ontario's CHC, British Columbia's Non-Hospital Replacement Program and aspects of the Long-Term Care and Homemaker Services programs.

Welfare services include Ontario's Homemakers and Nurses Services (COMSOC) and British Columbia's Family Support Homemaker Services (Human Resources).

b) Combined acute and chronic care programs and separate "welfare services".

Alberta's Co-ordinated Home Care program provides both chronic and acute care. Welfare services are provided by Family and Community Support Services.

c) Combined acute, chronic and welfare programs.

Manitoba's Continuing Care and Saskatchewan's District Home Care are based on this model. In both cases, social assistance recipients requiring home care as defined by these two programs, receive it through an established integrated delivery system.

2. Continuum of entry criteria

All the home care programs reviewed have certain similar entry provisions. These are requirements for:

- Supportive family conditions and proper home environment.
- Unavailability of service from other sources.
- Cost of care less than alternative forms of care, over same period of time.
- Ability of the applicant to benefit from home care - it must be suitable and has to be demonstrated in some way.
- The person to hold a provincial health insurance card.

In virtually all cases these function as "knockout" provisions. That is, non-compliance is enough to keep applicants out; but satisfying them does not guarantee entry. In this sense they are all in fact second-order criteria.

Each program also has one or more first-order criteria; the satisfaction of which is both necessary for entry and in some places sufficient to overide failure to meet the second-order criteria.

These are:

- Physician's referral

  Alberta - CHCP
  British Columbia - Long Term Care
  Ontario - AHC and CHC

- Medical Service need

  Ontario - AHC & CHC
  Alberta - CHCP
  British Columbia - LTC

- Completion of Standardized Functional Assessment

  Manitoba
  Saskatchewan

It can be seen that there are two natural entry groupings. Those that require a medical service need also require a physician's referral; one without the other does not occur. Those that do not require a physician's referral do not require any specific medical service, i.e. Manitoba and Saskatchewan. However, there is a major difference between Manitoba and Saskatchewan. In the former, nurses or other professional staff always must perform the assessments; in Saskatchewan this happens much less frequently and is not a requirement. As well, Manitoba uses a somewhat more medically-oriented concept of what constitutes a potentially entitling condition.

A continuum of entry criteria (least to most restrictive) would look like this:

- Saskatchewan is undoubtedly the most open; and closest to the so-called social entry provision. But in fact, as noted, the current system is a restriction of the previous, highly varied community approach to eligibility.

- Manitoba would come next in that it does allow entry for non-medical services; and does accept non-medical threats to independence as entitling, i.e. sudden loss of a care-providing spouse who had been tending a "frail" partner.

- Ontario and British Columbia are similar in that they provide both acute and chronic care programs; and both have a medical orientation. In both provinces, the social services departments operate programs primarily for actual or potential social assistance recipients.

- Alberta does have physician's referral and medical service criteria, but does not operate a separate chronic system for those with long-term needs. Rather, its long-term social support service is provided on a needs tested basis through a network of Family and Community Support Services offices. This single system combines some of the aspects of the separate chronic care and "social assistance entry" services operated in Ontario and British Columbia.

- Ontario and Alberta appear to have the most restrictive entry criteria.

V

AN INTER-PROVINCIAL COMPARISON OF ENTRY RULES AND RELATIONSHIPS

A. PURPOSE OF INTER-PROVINCIAL COMPARISONS

The main purpose of this study is an examination of the effect which possible changes to ME, will have on the effective demand for Alberta home care; and to consider the consequences of effective demand changes on program costs and staffing requirements.

In a rigorous social science experiment, all the factors shaping responses to entry changes would be identified and the options introduced under controlled conditions. This is not possible. Therefore, a next best approach must be used.

This chapter examines the actual entry experience of Alberta, and of other provinces with entry rules which are of potential policy interest to Alberta. By a comparative analysis of differing entry criteria and programmatic outcomes, we have sought to illuminate the nature of this association. The analysis attempts to identify which aspects of entry criteria are related in a causal way to important program outcomes. After making suitable provision for other mediating factors, estimates can be made of the effect such entry criteria would likely have in Alberta. This will be undertaken in chapter VI.

The comparison also helps to identify the degrees of similarity which exist between Alberta and other programs. This is crucial in locating those forms of provincial experience which are most likely to be applicable to Alberta.

Eight key dimensions have been selected for this analysis.

- admission rate
- rejection rate
- referral patterns
- age of entrants
- sex and marital status of entrants

- diagnostic and treatment classifications
- type of service and length of stay
- status at discharge.

In each, within the limits of the available data, provincial experiences are described and related to their respective entry rules. This is done from the point of admission to the point of discharge.

1. Identification of provincial programs compared

For purposes of data comparisons, the following provincial programs were used:

1. Ontario - The acute and chronic home care programs of the Ministry of Health. COMSOC's program was not included as no data were available.

2. Manitoba - The provincial home care program operated by the Continuing Care Division.

3. Saskatchewan - The new district home care program operated by the Department of Social Services.

4. Alberta - CHCP. For purposes of consistency, FCSS was not included, except as indicated.

5. B.C. - The hospital and non-hospital replacement programs operated by the Department of Health; and its homemaker program. The Human Resources Family Support Homemaker Service program was not included both to be consistent with Ontario and because no data were available.

2. Main sources of comparative data

Unless otherwise indicated, all comparative data are taken from the following sources:

Ontario: The 1979 - 80 annual report.

Manitoba: The annual reports for the years indicated.

Saskatchewan: The site visits or other direct contact with the program.

Alberta: Special runs from the CHCP data base. These were made on June 12, 1981 and August 6, 1981.

British Columbia: The site visit report.

Extensive use was also made of other documents. These include the Home Care Objectives Review Study (1980), and the Profile of Older Persons In Alberta (1980).

Frequent use was made of the Manitoba/Canada Home Care Study published by Manitoba's Office of Continuing Care and National Health and Welfare. It should be noted that many of these data were collected over a two month period (February and March 1978) from a sample of 1,167 persons admitted to the program during that period.

Most inter-provincial comparisons are for the fiscal year 1979 - 80. This was the most recent year for which data were available from all provinces.

An annotated bibliography of major articles which were drawn upon is contained in the Appendix. In addition, some 42 other studies and 27 journal articles on home care were reviewed.

3. Interprovincial comparison of home care terms

One possible element of the study was a comparison of the meanings assigned in different provinces to key terms, such as diagnostic-categories, types of care, treatment goals, patient status descriptors and forms of service.

The provincial visits suggested that there is a basic barrier to the creation of a "dictionary" of provincial home care terms.

This is the general absence of authoritative and standardized operational definitions within each one of the four provinces visited. For interprovincial comparisons of terms to have much value, there must be consistent usage within each jurisdiction. Except for the standard definition of certain medical terms which can be found in the International Classification of Diseases, this has generally not occurred.

This extends, for example, to such basic record-keeping concepts as "active caseload". Much of the comparative data available fails to distinguish in any precise way between admissions and active caseloads. Therefore, while an inter-provincial comparison of admissions was possible, the same could not be done, to the same extent, for the active caseload dimension.

There are a number of reasons for intra-provincial variations in terms.

- The responsibility of several departments and agencies for program rules and definitions (Ontario, B.C.).
- A high degree of local autonomy in the delivery of care, and thus in the use of terms (Saskatchewan).
- The presence of different professions or disciplines, each with its own "correct" terms (all provinces)
- The relative newness of province-wide comprehensive home care.
- High staff turnover.
- The evolution and continued re-definition of many terms.
- Competing philosophies of care.

Professor Evelyn Shapiro, whose comparative study of the nation's home care programs was published in 1979, has attempted to stimulate interest in the formulation and application of common Canadian terms. This has not, as yet, been successful.

The director of the Manitoba home care program is highly skeptical of the value of formalized definitions or the use of such things as diagnostic categories; especially as indicators of program performance. Such diagnoses only have value at the individual level; and she feels that age is likely to be a better indicator of need. Medical conditions and their classification are seen as being important only as they impact on the ability to function in the home. Indeed, in its new admissions form, Manitoba has dropped the use of treatment goal classifications altogether.

We therefore conclude that to this point in the development of provincial home care programs, common terms are not used widely enough within provinces other than Alberta to make such inter-provincial comparisons an effective aide to understanding the reality of daily practice across the country.

B. ADMISSION RATES

The first and in some ways the most significant comparative measure of effective demand is the number of total admissions. Exhibit V-1 shows home care admissions for each province.

EXHIBIT V - 1 Home care admissions relative to provincial populations

1979 - 1980

Number of Home Care Admissions per 1,000 pop.

Province*	Population	Total Admissions*	No. of admissions per 1,000
British Columbia	2,572,700	51,918	20.2
Ontario	8,572,800	78,536	9.2
Saskatchewan	959,500	7,711	8.0
Manitoba	1,045,400	8,330	8.0
Alberta	2,026,000	9,155	4.5

(all population figures are taken from population projection no. 2, Statistics Canada publication 8-1300-501 p. 159)

*Figures do not include those served by the needs tested, family support programs in Ontario, Alberta or B.C.

Obviously, by this particular measure Alberta's program in 1979 - 80 was admitting proportionally fewer people than the other programs. Ontario, Manitoba and Saskatchewan cluster together. Their admissions per 1,000 averaged 8.40, 86.2% greater than the Alberta figure. British Columbia's admissions exceed Alberta's by 347%. Ontario is proportionally admitting about

two people for each one admitted in Alberta; British Columbia admits five for each Alberta entrant. Of course, entry criteria are only one factor affecting the admissions rate. Length of time the service has been locally available, means of access, publicity and especially the percentage of those over 65 in the provincial population are all contributing variables.

Comparative data are available only on the over-65 variable. Exhibit V-2 shows admission rates in relation to the proportion of those over 65 in the population.

EXHIBIT V - 2 Home care admissions relative to the provincial populations over 65

1979 - 1980

Province	Pop. over 65	% over 65	Home care admissions per 1,000 persons over 65
British Columbia	266,600	10.4	194.7
Ontario	802,700	9.4	97.8
Manitoba	114,400	11.0	72.4
Saskatchewan	110,500	11.5	69.7
Alberta	152,500	7.5	60.3

Compared this way, the rank order is only slightly changed. Manitoba and Saskatchewan exchange positions. The Manitoba/Saskatchewan average exceeds the Alberta figure by 15%. The percentage of those over 65 in Manitoba and Saskatchewan exceeds the Alberta figure by 49.7%. On the other hand, the percentage of Ontario's elderly exceeds Alberta's by only 24%, while its home care admissions are 37% higher. British Columbia has an elderly percentage 38% greater than Alberta's, while its admissions are 223% higher.

Alberta's CHCP is admitting fewer people than the other provinces. In terms of entry rate, Manitoba and Saskatchewan are most similar to that of Alberta. The programs with the highest entry rates are Ontario and B.C. As already noted, this is the result of a number of factors; but the fact that these are the two systems with separate chronic, acute and family support programs is almost certainly one contributing factor.

C. REJECTION RATES

The obverse of the admission rate is the rate of rejections. Exhibit V-3 shows the rejection rate as a percentage of total applications.

EXHIBIT V - 3 Rejected applications for home care as a percentage of total applications

Province	Total Applications	Rejections	Percentage
Ontario	92,180 (1979 - 80)	13,644	14.8%
	acute 84,953	13,207	15.55%
	chronic 7,227	437	6.05%
Manitoba	9,504 (1980)	668	7.03%
Alberta	6,805 (July - Dec./80)	1,763	26.0%

Rejection figures are not available for British Columbia or Saskatchewan. In the latter case, however, an educated guess would place rejections in the 7 - 12% range.

The new Alberta program had a rejection rate considerably higher than the older programs in the other provinces. It is 3.6 times higher than Manitoba's and 4.3 times higher than the chronic program in Ontario. It is not possible to isolate the influence of program age, but the Manitoba rejection rate has been remarkably constant. It was 8.5% for the month of July, 1975, the first month for which standard statistics were collected for the new program. For March 1981, the most recent month on which figures are available, it was 7.9%. Program officials believe this slight decline is the result of better public education about the program. In this dimension, Alberta's experience in the years for which comparative figures are available is closest to that of Ontario's.

In Alberta, the largest single reason for rejection (631 of 1,763, or about 36% of the rejections in the period surveyed) is "no medical services required". Perhaps as much as 45 - 50% of those refused are ineligible because of the present medical entry provision. Other applicants, such as some percentage of the 146 rejected because they were "ambulant" would also become eligible with a broadening of ME_1.

D. REFERRAL PATTERNS

Exhibit V-4 shows the primary sources of referrals to CHCP.

EXHIBIT V - 4 CHCP source of referrals (1980)

Referred by:	All Ages %	Over 65 %
Physician	20.1	22.3
Hospital	37.9	36.0
Self or Family	14.7	17.3
Friends or relatives	2.5	3.1

The over/under 65 dimension has no significance aside from a small but steady increase in self or family referrals as age increases.

This can be compared with: Manitoba's referral pattern between 1975 and 1981 (Exhibit V - 5).

EXHIBIT V - 5 Referral sources -- Manitoba (all ages)

	1975 (July) (%)	1981 (March) (%)
Physician	22.9	23.6
Hospital	34.3	46.0
Family/Friend	19.6	14.2
Self	8.7	7.8
Other agency	10.0	5.1
Home Care programs	4.5	3.2

The only significant shift is an increase in the referrals from hospitals of about one-third; and about a 25% decline in the proportion of referrals by families and friends.

It will be seen that the Manitoba and Alberta programs are roughly similar in this dimension. The percentage for physician referrals are almost identical. If one adds to the Alberta general hospital referrals from other hospitals, the figure is close to that of Manitoba. The combined percentage for self, family and friends for the over 65's in Alberta is 20.46%. In Manitoba, it is 21.98.

Despite different entry criteria, there appears to be a similar underlying pattern between Manitoba and Alberta on this component of the actual operation of the intake process.

Ontario's pattern, however, appears to be somewhat different. Exhibit V - 6 shows the Ontario picture.

EXHIBIT V - 6 Ontario referrals 1979 - 80 (partial list)

	Acute	Chronic
Acute Hosp.	67.4	37.3
Extended Hosp.	1.1	1.9
Community agencies	23.6	37.3
Nursing home	2.7	.7
Other home care	.4	23.3

The Alberta pattern resembles the chronic more than the acute experience in Ontario.

This is an indication that ME, may have functioned to create an intake process which somewhat more closely resembles the Ontario chronic program or the social support-oriented program of Manitoba than it does the acute program of Ontario.

E. AGE FACTORS

The distribution of home care entrants across the age categories and in particular the percentage over 65 is a major comparative descriptor of home care programs.

Exhibit V - 7 compares the age distribution of home care recipients in Manitoba and Alberta. (Figures for other provinces were not available).

EXHIBIT V - 7 Comparison of those receiving home care in Manitoba and Alberta (1980)

Age group	Manitoba	Alberta
0 - 18	3.2%	2.1%
19 - 64	23.2%	26.3%
65+	73.6%	71.0%

The age distribution for the two programs is quite similar.

Figures on the percentage of recipients over 65 were available from other provinces. These are presented in Figure V - 8.

EXHIBIT V - 8 Percentages of those admitted to home care who are over 65 (1979)

Province	Percentage
Manitoba	75.3%
Saskatchewan	71.0%(estimate)
Alberta	68.3%
Ontario	59.0%
British Columbia	51.4% (estimate)

It will be noticed that those two provinces with the specialized acute programs have the smallest proportion of patients over 65. This is probably not a coincidence. The older one becomes the greater the propensity for the co-occurence of compounding medical problems with social complications. Older persons are less likely to meet short-term, acute criteria.

Alberta's position in the middle is consistent with the absence of either a strictly acute care filter or of a social entry provision. This and other

evidence suggests that Alberta currently sits between the two entry poles of acute care and social entry; but is closer to the latter than the former in the profile of its entrants.

One possible effect of ME_1 is to produce patients with an age distribution which more closely resembles those of Manitoba and Saskatchewan than it does British Columbia or Ontario.

F. SEX AND MARITAL STATUS

Typically, home care recipients are more likely to be females. Exhibit V - 9 compares the proportion of female home care recipients in Manitoba and Alberta.

EXHIBIT V - 9 Home care admissions by sex

	Male (%)	Female (%)
Manitoba[1]	33.6	66.4
Alberta[2]	35.4	64.6

[1] 1978 figures
[2] 1980 figures

The two provinces are very similar on this dimension. Again, there is apparently no effect of entry criteria.

The higher presence of single or widowed (the number of divorced and separated clients are too small to be of interest) persons in home care has been widely observed. Exhibit V - 10 compares marital status of Manitoba and Alberta recipients.

EXHIBIT V - 10 Recipients of home care by marital status

	Single (%)	Married (%)	Widowed (%)
Manitoba[1]	9.43	46.53	39.50
Alberta[2]	12.44	42.13	35.8

[1] 1978 figures
[2] 1980 figures

The Alberta program provided service to relatively more single and fewer widowed persons. The differences are in the range of 10% for the widowed category. The differences in the number of single persons is more significant. The lower average age in Alberta is probably the major explanatory factor for the differences in marital status of the two provinces. Exhibit V - 11 shows the relationship between age and marital status in Alberta.

EXHIBIT V - 11 Alberta home care recipients (1980)

Age group	Single	Married	Widowed
65 - 74	7%	50%	39%
75 - 84	5%	38%	53%
85 - 99	14%	17%	46%

With aging, the probability of being married declines sharply and the percentage who are single and widowed goes up. This underlines the point that along with medical conditions, the "old" are increasingly likely to have a need for support services to stabilize their environment and replace the functions of lost spouses.

Figures for other provinces were not available.

G. DIAGNOSIS AND TREATMENT

1. Diagnostic category

The types of services patients require are related to their presenting conditions. For 1980, the main CHCP presenting conditions are presented in Exhibit V - 12.

EXHIBIT V - 12 CHCP diagnosis of condition at time of entry

Diagnostic Category		Proportion in Category: Patients Under 65 (%)	Proportion in Category: Patients Over 65 (%)	Percentage of patients in main diagnostic categories - Alberta 198 (%)
1.	Circulatory	16.4	83.6	22.0
2.	Musculo-Skeletal	21.4	78.6	13.6
3.	Neoplasms	42.2	57.8	8.8
4.	Nervous System	46.7	63.3	8.5
5.	Endocrine-Metabolism	30.3	69.7	8.0
6.	Accident/Violence	31.4	68.6	8.0
7.	Digestive	42.2	56.8	6.2

Of these seven categories, four display quite marked variations between the aged and non-aged populations. The aged are much more likely to require entry as a result of accidents, and to have endocrine-metabolism, musculo-skeletal or circulatory problems. If entry changes led to an increase in the number of entrants over 65, this would likely mean an increase in the number of persons with these particular diagnoses.

There is also a relationship between age and the type of care required. This is illustrated in Exhibit V - 13.

EXHIBIT V - 13 CHCP patients - type of care required

Type of Care required	Percent of under 65's	Percent of over 65's
Acute	37.2	17.1
Rehabilitation	27.0	22.9
Chronic	27.2	55.0
Palliative	8.7	5.0

It can be seen that more than one person in three under 65 is admitted for acute care; but less than half that number among those over 65 require acute care. Conversely, the number over 65 diagnosed as having a chronic condition is double the rate for those under 65. Indeed, for those aged 80 - 84, the percentage needing chronic care is 61.68 and for those 85 - 89 it is 72.5%. There is a strong association in Alberta between advancing age and the need for chronic care.

This raises the possibility that entry changes which altered the age distribution could be expected to also alter the service mix. Changes favoring the young would likely increase the demand for acute nursing care; while changes favoring the elderly would likely cause an increase in the need for chronic care and support services.

Unfortunately, information on diagnostic categories and type of service was readily available only from Manitoba and Ontario. Neither one, however, regularly produces data on the relationship between diagnostic category and type of service required.

The seven leading diagnostic categories in Manitoba are shown in Exhibit V - 14.

EXHIBIT V - 14 Distribution of patients by diagnostic category in Manitoba (1978)

Diagnostic category		Percentage of total diagnoses	Proportion in Category	
			Percent of under 65's	Percent of over 65's
1.	Cardiovascular	34.6	20.1	79.9
2.	Musculo-Skeletal	16.1	22.2	79.3
3.	Endocrine/Metabolic disorders	14.5	30.2	69.8
4.	Cancers	14.4	36.4	63.6
5.	Mental and Central Nervous System Disorders	12.6	34.7	65.4
6.	Fractures/Injuries	12.6	29.6	70.4
7.	Respiratory	10.4	19.7	80.3

Source: all Manitoba data are from the Manitoba/Canada Home Care Study p. 50

The first observation is that six of the seven top Alberta categories are also present on the Manitoba list. Only "digestive" is not and it was ranked seventh in order of significance. The only Manitoba category not on the Alberta list is "respiratory"; and in fact it is in eighth place in the full Alberta list.

The rank orders are strikingly similar: Cardiovascular (or circulatory) conditions top both lists; and musculo-skeletal problems are second. Neoplasms (or cancers) are third in Alberta and fourth in Manitoba. Endocrine-metabolic is third in Manitoba and fifth in Alberta. Accidents and injuries are 6th in both lists.

As to the over/under 65 distribution of occurance, the similarities are quite striking. The musculo-skeletal caregory shows:

	Under 65	Over 65
Manitoba	22.28%	79.35%
Alberta	21.36%	78.64%

Manitoba's endocrine-metabolism category has (under/over 65) 30.18/69.82 percent and Alberta's 30.28/69.72 percent. The only category showing a difference worth mentioning is the nervous system. Manitoba is 34.69/65.31 percent while Alberta is 46.74/53.26 percent. This may simply reflect a younger Alberta population.

Overall, these figures suggest that Manitoba's use of a more extensive functional assessment and somewhat less involvement by physicians in the entry process appears to have no effect on the diagnosed categories of need.

These figures also suggest that Alberta could undertake changes to entry criteria which would lead to a greater demand for support services, such as provided in the Manitoba system, without anticipating any significant shift in incidence of diagnostic categories as a result.

Exhibit V - 15 shows the leading diagnostic categories in Ontario.

EXHIBIT V - 15 The seven leading diagnostic categories in Ontario 1979 - 80

Diagnostic category		Percentage of admissions (incomplete)
1.	Neoplasms	9.4
2.	Injuries	9.1
3.	Musculo-Skeletal	8.9
4.	Digestive System	7.6
5.	Circulatory System	7.3
6.	Skin and subcutaneous tissue	7.2
7.	Cerebrovascular diseases	6.0

This list, while not fundamentally different from the previous two, is not as similar to Alberta's as is Manitoba's. In particular, musculo-skeletal disorders are substantially lower in Ontario.

The obvious conclusion is that CHCP already has the diagnostic characteristics of longer-term programs with a highly modified medical entry provision.

2. Treatment Goal

One would expect the treatment goal set when patients enter a program to be affected by the entry criteria. Exhibit V - 16 compares treatment goals in Alberta and Manitoba. While the comparison is somewhat confounded by definitional problems, the figures are nevertheless informative.

EXHIBIT V - 16 Comparison of treatment goals

Projection	All Ages (%)	Proportion in Category: Recipients Under 65 (%)	Recipients Over 65 (%)
Manitoba (1978)			
Rehabilitation	35.8	43.8	56.2
Maintenance	46.1	16.4	83.6
Deterioration	18.1	28.9	71.1
	100		
Alberta (1980)			
Rehabilitation (partial & full)	49.3	40.3	59.7
Maintenance	45.0	18.5	81.5
Palliative	5.7	46.0	54.0
	100		

The Manitoba program has about one entrant in five whose condition is so severe as to be certain of deterioration after entry. Many of these people have degenerating diseases such as multiple sclerosis or cancers. Seven out of 10 are over 65. Alberta has only one person in 20 in this group and they are almost evenly divided between those under and over 65. Conversely, Alberta has a higher proportion of entrants who it is thought can be (fully or partially) rehabilitated. Indeed, about half the people entering the program are in this class. For Manitoba it is only one in three. The under/over 65 division here is however, quite similar. This suggests, as do previous data, that relative to Manitoba, the Alberta entry process is more likely to admit persons with relatively treatable medical conditions. This is what ME_1 calls for and as these figures show, it is in fact achieving that result.

The main difference between the two programs is that those over 65 with a chronic/degenerating condition are admitted to the Manitoba program in much higher numbers.

So while the types of conditions the entrants to the two programs have are likely to be the same, in Manitoba their health status is less likely to be improved and such persons are going to require a significantly higher level of support services as the degree of deterioration grows. ME_1 presently spares CHCP some significant proportion of these potential costs.

The Manitoba experience suggests that Alberta could expect significant increase in the number of persons with degenerative diseases or terminal illnesses, were it to modify ME_1 to permit entry of persons whose declining physical state required support services rather than medical treatment. And of course, the growth in cost per case would be disproportionately greater than the percentage case load increase.

H. TYPE OF SERVICE AND LENGTH OF STAY

Our analysis suggests that type of service is related to the length of stay. That is, three kinds of service patients typically receive vary in relation to the time elapsed between entry and discharge. This relationship is demonstrated in Exhibit V - 17.

As can be seen, the receipt of nursing increases steadily over the first two months; and then drops sharply. It declines steadily until the figure comes to include all persons on the program more than 187 days. Of all those receiving homemaking, exactly 50% are discharged in 61 days or less. A similar distribution is noted for homehelp and meals. For those receiving nursing, 49.3% were discharged in 61 days or less.

A majority of those receiving personal care are in fact long-stay patients. For homehelp and homemaking, one in three and one in four respectively are still on after 187 days.

Exhibit V - 18 shows the percentage of the total number of patients receiving each type of service who were discharged in 31 days or less.

EXHIBIT V - 18 CHCP services received by those discharged in 31 days or less

Service	% discharged
Nursing	31.7
Homemaking	24.7
Therapy	20.6
Personal Care	8.7

EXHIBIT V - 17 Actual length of time on CHCP for those receiving designated services - 1980

	Discharge Date (Days Elapsed) Percentage							
	0-14	15-31	32-61	62-93	94-124	125-155	156-186	187+
Percentage of those receiving Nursing discharged in each time period (Codes 20,22,23,24,29)	16.03	15.63	17.60	11.99	7.31	5.53	4.06	21.85
Therapy (Codes 25,26,27,28)	6.45	14.12	20.13	17.10	9.57	6.45	4.96	21.21
Homemaking (Code 40)	10.42	14.24	18.54	11.74	9.58	5.83	5.00	24.65
Homehelp (Code41)	4.85	10.49	17.28	12.72	7.86	6.60	5.53	34.66
Personal Care (Codes 30, 52)	3.51	5.18	10.52	10.52	6.84	6.01	6.01	51.42

Of all those receiving nursing in 1980, almost one-third were discharged after one month. In other words, much of the nursing went to those who were short-stay patients. About one in four of the homemaking recipients and one in five of the therapy recipients left the program in the same period. In contrast, only one person in 12 receiving personal care was discharged after 31 days.

These figures can be compared with those still on the program after 187 days. The percentages in Exhibit V - 19 indicate the proportion of total recipients of each service not discharged after the 187th day.

EXHIBIT V - 19 CHCP services received by those discharged after 187 days

Service	Percentage
Personal Care	51.4
Homehelp	33.0
Homemaking	24.6
Nursing	21.9
Therapy	21.2

It is possible, therefore, to conclude that entry changes which lead to longer length of stay will affect the type of service required. This change will be in the direction of more personal care, homemaking and homehelp services, and less nursing. The demand for rehabilitation therapies seems to be the only service type which is insensitive to the length of stay. (This may reflect, however, the relative scarcity of rehabilitation services at the present time).

Unfortunately, no comparative data on this dimension were available from the other provinces.

I. DISCHARGE

Finally, we examined where patients go upon discharge from home care. When viewed comparatively, these figures tell us something about the likely impact that a change in entry rules can have upon discharge patterns and the related demands on the community and care giving institutions.

Exhibit V - 20 shows the major post-discharge locations. (The figures exclude those not classified as to health status).

EXHIBIT V - 20 Main locations of CHCP patients after discharge (1980)

Location	Percentage
1. Home - no further care required	31.1
2. Hospitals - acute and extended	21.1
3. Community Health & Social agencies	14.8
4. Home - some care required by friends and family	13.9
5. Deceased	7.0
6. Nursing Homes	4.0
7. Lodges	1.3

As can be seen, about 45% of those discharged required no further formal care. Another 15% remained at home but required service from some public service external to the home.

Just over one in every five was discharged to a hospital of some type. The proportion remaining at home with no publicly financed form of care is almost identical to the proportion of those who improved their state (achieving either full or partial rehabilitation) of all those discharged and classified as to health status at that time (Exhibit V - 21).

EXHIBIT V - 21 Condition of CHCP patients at time of discharge (1980)

Condition	Percentage
1. Condition maintained	25.8
2. Partially rehabilitated	23.9
3. Fully rehabilitated	21.7
4. Deteriorated	21.5
5. Deceased	7.0

Overall, about 46% improved their state; about 29% either deteriorated or expired; and 26% retained the same status as at entry.

In 1980, 66.7% of those classified as to health status at time of discharge were over 65. Exhibit V - 22 shows the condition of those over 65 at time of discharge.

EXHIBIT V - 22 Condition of those over 65 at time of discharge from CHCP

Condition	Percentage
Condition maintained	27.6
Condition deteriorated	25.2
Partially rehabilitated	22.7
Fully rehabilitated	17.1
Deceased	7.4

For the year examined, about one out of every three persons either deteriorated or died while on CHCP. About one person in four maintained his or her level of health at time of entry; while the remaining 40 percent made some improvement.

With a program having so high a percentage of older persons with a chronic condition, it is not surprising to find that as age increases, the achievement at discharge of the goal established at intake also declines. This is shown in Exhibit V - 23.

The CHCP trend is evident: the possibility for medical "recovery" in whatever sense, declines steadily from almost two out of three to about one in six; and the need for institutional placement goes from one in 20 to about one in four.

EXHIBIT V - 23 Age of those meeting treatment goal or needing institutional placement

Age	% meeting goal	% needing institutional placement
0 - 19	63.1	4.7
20 - 29	60.1	7.1
30 - 39	53.2	7.8
40 - 49	40.0	12.2

EXHIBIT V - 23 cont'd

Age	% meeting goal	% needing institutional placement
50 - 59	39.9	11.9
60 - 64	34.8	15.1
65 - 69	34.4	13.4
70 - 74	22.8	15.0
75 - 79	28.6	17.5
80 - 84	26.6	18.6
85 - 89	17.9	23.6

The number achieving full rehabilitation is, however, somewhat smaller than one would expect for a program geared to those with treatable medical conditions. A comparison with Manitoba and Ontario may be instructive.

Ontario discharges 59% of its acute recipients but only 25.4% of its chronic care patients to their homes, with no further treatment required. Some 17% of the AHC program's discharges go into active treatment hospitals, compared to 52.4% from CHC, while 5.1% get public health system support. Nursing homes take 34% of those leaving AHC.

In 1980, Manitoba discharged 36% of its patients to their own homes with no further care required; while another 14% needed some care from themselves or relatives. In all, 51.2% were discharged without any further requirement for care from any source external to the home.

In March, 1981, Manitoba placed 16.5% of its discharged into acute or extended care hospitals and 8% into nursing homes. For all of 1980, about the same percentage of discharges went into these institutions. Manitoba placed in percentage terms, about twice as many patients in nursing homes as Alberta and about 30% more into acute or extended care hospitals. Alberta on the other hand placed about 15% of its discharges into some form of community care which is virtually absent in Manitoba.

The other main difference is that Manitoba's mortality rate was almost three times as high as Alberta's. This and the higher nursing home admissions are entirely consistent with the somewhat older and more chronically afflicted nature of Manitoba's entry population. But it makes all the more noteworthy Manitoba's rate of full or partial rehabilitation.

J. SUMMARY

The following points have emerged from the analysis:

- The B.C./Ontario and Manitoba/Saskatchewan programs seem to cluster together on a number of program dimensions. This includes age and entry rate.

- Alberta at present seems to fall somewhere between these poles on the dimensions observed; but closer to the support service pole and seems to have an active caseload with similarities to that of Manitoba.

- The main differences between Manitoba and Alberta have to do with a higher presence in Manitoba of persons who cannot be rehabilitated; and the larger number of its entrants receiving non-medical services such as homemaking and homehelp.

- Those factors which seem to be associated with entry criteria variations, and which may therefore be particularly sensitive to entry changes, are as follows:

  - admission rate
  - rejection rate
  - age of entrants
  - referral pattern
  - length of stay
  - type of service received
  - status at discharge

- Those factors which on the basis of the evidence available, show no strong evidence of being associated with entry criteria are as follows:

  - sex
  - marital status
  - diagnostic category

- Medical entry criteria tend to produce a caseload which is relatively:

  - younger
  - has greater rehabilitation potential
  - less likely to receive support services
  - discharged more quickly
  - higher in effective demand.

► Entry criteria stressing functional capacity tend to produce a caseload which is relatively:

- older
- has less rehabilitation potential
- more likely to receive support services
- discharged more slowly
- lower in effective demand.

► On balance, the Alberta caseload more closely resembles the latter than the former.

VI

ANALYSIS OF ENTRY OPTIONS

A. DEFINING ENTRY OPTIONS

As discussed in Chapter IV, entry criteria lie on a continuum from a strictly medical entry to a completely open "social entry". Rather than assess each point on the continuum, we have identified five major options. These options were selected because:

- They represent detectably different points on the continuum of entry models.
- They reflect the models of entry criteria presently in use in functioning home care programs.

B. OUTLINE OF ENTRY OPTIONS

1. No change

Alberta may choose to leave both ME_1 and present resource obligations unchanged. While this is perhaps not an attractive option, it is essentially the baseline condition. Growth in effective demand and cost and manpower projections if this option were adopted can serve as a useful contrast to the effects of other options.

2. Leave ME_1 intact; increase the local availability of the therapy and support services

Nursing is available in all CHCP's. The therapies and main support services are not available in many of the sub offices; and in a few LHA's some services are not available at all. So the second option is to leave ME_1 unchanged while enhancing the program's capacity to provide for the support service needs of patients whose acute medical needs may have already been met. A first step in this direction would be to require the actual provision by all LHA's and sub-offices of all entry services, i.e. the therapies; on the principle that if a service is important enough that a need for it is grounds for entry, it should be mandatory. This step

would have only a small effect on entry but it would allow admission to those now turned away because of the non-availability of entry services.

A more extensive version of this option would be to make selected support services available in all regions and sub-offices; and as second phase of this option, to reduce certain of the restrictions on their use.

3. Create separate acute and long term care or chronic systems

If the Department does not wish, either now or in the future, to meet the cost of more support services, a constriction of entry criteria should be considered. CHCP entry could be limited to those with a medical condition which is treatable and remediable over the short term. Future additional funding could then go toward more specialized forms of at-home medical care.

The related option then exists of continuing the current FCSS home care system or at some point upgrading it to provide care to both those with family support or "social assistance needs" and long-term chronic problems. The basic distinctions between the present FCSS program and a chronic care system paralleling the acute care CHCP system would be a) admissions on the basis of a functional assessment rather than the needs test, and b) the provision of some degree of nursing in addition to the support services.

The acute/chronic division has the merit of confining patient access to the more specialized and expensive nursing services, and to the less expensive but more heavily utilized long-term support services, to some portion of the total home care recipient population.

Whether this specialization of entry criteria and of service is less expensive than the comprehensive approach is affected by the degree of control the government retains over admission rules and practice.

Entry to an acute care CHCP could be restricted either by imposing a length-of-stay limit, as in Ontario, or by requiring the presence of major medical impairments. If the latter course were adopted, the program could become essentially hospital-centered, restricting itself to those discharged from, but continuing under the treatment of, hospital staff. For a model of this type, the program operated by the University Hospital in Saskatoon is recommended for review. The one operated by Boston's Massachusetts General Hospital is another prototype.

4. Retain the requirement for a medical condition but establish one or more additional entry services (ME_2)

The present system requires the presence of a medical condition which needs treatment by a nurse or therapist. The least discontinuous expansionary change would be to maintain the requirement that entrants have an observable medical condition. Admission, however, would also be granted to those whose conditions, while not requiring treatment at home by a physician or other health practitioner, do give rise to specific functional limitations which threaten the ability to live independently.

Entry services would be expanded to include homemaker and/or other support services. The expansion could initially be limited to those support services which are at present available in any particular LHA. Alternatively, the expansion could take the extreme form of removing the requirement for any particular support service. In this case, admission would be granted to anyone with a medical problem jeopardizing independent living, who needed any available service.

5. Adopt a "Social Entry"

The final major option is to remove altogether the necessity for the existence of a medical condition. Emphasis would then be placed in providing specific services needed to avoid institutional placement, in response to either medical or non-medical problems. This is the "social entry point" such as is present in Saskatchewan.

6. Summary

The five options and their differences from existing criteria are summarized in Exhibit VI - 1.

C. PRELIMINARY EVALUATION OF ENTRY OPTIONS

As a preliminary step, we evaluated each of the five options in terms of their compatability with the existing home care system and the province's policy objectives. After this assessment, we excluded two of the options from further assessment: "Separate Chronic/Acute Care Systems" and "Social Entry".

Exhibit VI-1. Summary of Options

P = Partial change
B = Basic change
N = No change

OPTIONS	ME$_1$ COMPONENTS: Medical Condition	Observed by Physician	Treatable Medically	Require Nursing
ME$_1$: No Change.	N	N	N	N
Mandatory Provision of All Entry Services; Add Support Services	N	N	N	N
Separate Acute/ Chronic System	N	N	N	N
ME$_2$: Non-treatable medical condition; Additional Entry Services	P	P	B	B
Social Entry	B	B	B	B

1. "Separate Chronic/Acute Care Systems"

This option would require a complete re-structuring of the CHCP program. A main issue would be: who delivers the chronic care program: The LHA's or the FCSS system?

If the answer is F.C.S.S., a major upgrading and filling-in of the missing pieces of home care service is required. This could take two - three years. In the interim, what would happen to those people who had been eligible for CHCP but were not in need of acute care? It would be probably quicker and more reliable to have the additional service delivery done by the LHA's. But this would mean - if duplication is to be avoided - taking some homemaking and other support services away from the F.C.S.S. program. While this would make some sense programmatically, it would be a highly unpopular step. Furthermore, this approach would mean the existence of three home care programs: distinct chronic and acute systems under the LHA's and a separate system for family support.

Another disadvantage is the potential for very substantial growth in both the acute and chronic caseload. The acute care growth potential is quite high as can be seen in Ontario and British Columbia. As the number of aged persons with acute episodes increases, so will the caseload. Such a system could be subject to pressure from the medical community to increasingly cover those with complex medical problems who, with advancing medical technology could be kept at home. Such systems are feasible only as extensions of larger hospitals; and only in reasonable proximity to same. This has an obvious urban bias.

This option would represent a separation of programs, with the potential increased problems of care planning and service delivery co-ordination. Program overlap and duplication could result, as could intensified competition for resources. The difficulties and scope of the change inherent in this option may make it infeasible as a response to Alberta's immediate problem.

2. "Social Entry"

This option is rejected for Phase II. It is too discontinuous with the current operating ethos of the LHA's; and more importantly, would pose excessive support service manpower demands at a time of current unmet needs of those already in the system. Given the amount of support service such an option would require, relative to what is now available and being delivered, such a change would require a development period of two - three years before it could be implemented.

With so open-ended a program, a substantial and abrupt growth in the effective demand for service would occur. These expectations could not immediately be met, resulting in public criticism.

Upward pressure on program costs would be intense. The result, in short, could be sharply increased expenditures and public criticism.

D. DETAILED EVALUATION OF ENTRY OPTIONS

After the preliminary evaluation, three options remain:

"ME_1 - no change"

"Make all entry services mandatory; increase support services"

"ME_2"

Using the option of ME_1 as the baseline, we then developed estimates of the inputs of the remaining options for staff requirements and costs. In evaluating these impacts we use the concept of effective demand for home care.

1. Effective demand

Effective demand is defined as the incidence of formal applications for entry from persons who are eligible for one or more services.

There are four key indicators of the level of effective demand.

- The number of admissions, or Admission Rate over a designated period.
- The average duration of active enrollment for those newly entitled to entry; relative to the average duration of active enrollment for those already entitled to entry. Generally, the higher the average age of entrants and the greater the openness to those with non-medical disfunctions, the longer the enrollment. The operational concept here is Active Caseload.
- The type of services entrants require. Home care services vary in per unit cost by a factor of three or more, i.e. a nursing visit can be three times as expensive

as an hour of homemaking. So overall, program costs are quite sensitive shifts in the kinds of service entrants receive. The operational concept here is Service Mix.

- The amount of particular services received over any specified period is, ultimately the single most significant cost variable. An increase in the volume of a high intensity, low-cost service can equal the cost of a much smaller volume increase in a higher cost service. Utilization intensity is the operational concept here.

2. Background factors influencing effective demand

Of course, Entry Criteria are not the only or even necessarily the most significant, factors influencing effective demand. Additional elements can be broadly classed into three groups. These are:

a) Program Development Variables.

The length of time the program has had to establish a delivery system, recruit and train staff and create operating links with referring agencies. Other than the start-up data of each program; no data on these are presented here.

b) Awareness and Attitudinal Variables.

It takes time for people to learn about any program and to understand when and how it should be used. This is essentially a learning curve.

In addition, there is an attitudinal factor. This describes the degree of acceptance of the program, once they do learn about the program, by those who are potential applicants or referral agents.

This factor may be one of considerable significance; but no data were available for this study and thus no further analysis is possible here.

c) Demographic Variables.

These are factors which affect the potential demand for home care. That is, they contribute to changes in the size of the population sub-groups, whose members have a significantly greater probability of need than does the general population: The literature is far from unanimous; but there is some agreement that the following groups are especially significant in contributing to the demand for home care. (Duke University, Centre for the Study of Aging and Human Development, Multi-dimensional Functional Assessment, 2nd edition, Durham, North Carolina, 1978, pp. 75 - 99; also Evelyn Shapiro, Home Care: a Comprehensive Overview, National Health and Welfare, Ottawa, 1979, pp 19-20).

The critical demographic factors are:

- The number of persons in the population over 65; and more particularly, the number of persons over 75. Generally, the greater the number of aged persons, the greater the demand for care. However, the relationship between the rate of growth in the number of the aged and the rate of increase in demand is not linear. Rather, it will be affected by a number of additional factors, some of which are also examined.

- The proportion of females to males. The demand for home care among females is considerably greater than from males. But again, one cannot expect that a given percentage increase in the female population will be expressed in an equally sized increase in the percentage demanding care.

- The number of persons living alone. Again, experience indicates that those who live by themselves are more likely to need care, especially support services taking the place of a spouse of other family member.

E. MAIN DEMOGRAPHIC TRENDS AFFECTING FUTURE GROWTH

There are three demographic trends which are particularly crucial for estimating future home care demand. These are:

- the number of those over 65 (it should be noted that it is the increase in the actual number of those over 65; not the percentage shifts which has the main impact on caseloads);
- the increasing proportion of females to males;
- the increasing number of females over 65 and especially over 75;
- the number of females living alone.

1. Number over 65

According to the Alberta Bureau of Statistics, in 1976 the over-65 population stood at 137,900. During the period 1976 - 1986, this population is expected to grow at an average annual rate of 3.9 percent. Projected Alberta population over 65 is shown in Exhibit VI-2.

EXHIBIT VI - 2. Alberta Population Aged 65+

Year	65+ pop.
1981	162,500
1982	167,900
1983	173,400
1984	178,800
1985	185,300
1986	191,700

Source: Population Projections Alberta: 1977 - 2006, p. 8.

This is an increase over the five years of 27,900 or 17.7%. At the same time, the total provincial population will grow by an estimated 19.2%.

Using the same population projections, we examined the estimated percentage of the total population over 65 in each of three age categories: 65 - 74, 75 - 84 and 85+. We found that the percentage in each category changed only marginally over the period to 1986. Therefore, home care entry would not appear to be affected by significant shifts in the age distribution within the over-65 population as a whole, to 1986.

2. Percentage of females

The percentage of males to females will undergo a shift of greater size. (Exhibit VI-3)

EXHIBIT VI - 3. Sex Ratios, Alberta Population Aged 65+

Year	Percentage Males	Females
1981	45.3	54.7
1982	45.0	55.0
1983	44.5	55.5
1984	44.1	55.9
1985	43.9	56.1
1986	43.6	56.4

Source: Population Projections Alberta: 1977 - 2006, pp. 28 - 32.

The percentage of females in excess of males will increase from 20.5% in 1981 to 29.4% in 1986.

3. Number of females over 75

The number of females over 75 is projected to increase from 35,400 in 1981 to 44,200 in 1986, an increase of 24.9%.

4. Households and living arrangements

Statistics Canada forecasts the following changes in Alberta households:

EXHIBIT VI - 4. Living arrangements by sex

	1981	1986
All heads over 65	94,900	110,100
Males married (spouse present)	47,200	53,700
Males single	5,300	5,800
Males ever married - spouse absent	8,800	9,400

	1981	1986
Females single	2,100	2,500
Females ever married - spouse absent	31,600	38,700

Source: Household and Family Projections by Canada and the Provinces to 2001, p. 100

5. Summary

Over the five year time frame there will be:

- An 18% increase in total population over 65.
- A 43.4% increase in the proportion of females to males.
- A 21.8% increase in the number of females over age 75.
- A 22.5% increase in the number of females over 65 living without a spouse.

These trends will account for a major part of the longer-term demand response to any change in ME_1.

6. Effect on Entry 1981 - 1986

Even without entry changes, these factors will have an effect on demand for home care.

In 1980 - 81, about 5,400 females over 65 entered CHCP. This was about 6.1% of the total female population in this age group. If this percentage holds constant, then the increase in the ratio of females to males alone will have this impact on entry.

Exhibit VI - 5 shows the estimated impact of this increase.

EXHIBIT VI - 5. Estimate of number of females over 65 on CHCP, 1981 - 86

Year	Increase as result of male/female ratio
1981	5,416
1982	5,630
1983	5,874
1984	6,106
1985	6,356
1986	6,600

It can be seen that the impact of this factor by itself will be relatively small; about 1,200 persons or a 22% growth in entry as a result of the change in male/female ratio over 65.

We have estimated the number of 1980 - 81 female CHCP entrants over 75 at 3,300, or 9.6% of the total group in this age/sex category. If the proportions hold, this group by 1985 will account for about 4,250 CHCP cases; or an increase of 950 cases.

Taking the over-65 population as of April 1, 1981 of 162,500 and an estimated annual total senior citizens admissions of 8,179 gives a senior citizen CHCP admissions to total senior citizen population percentage of 5.03. If this percentage holds constant then normal CHCP admissions from the senior citizen increase alone will grow at this rate over the next five years.

EXHIBIT VI - 6. Total CHCP admissions as affected by projected growth in 65+ population

Year	Percentage of senior population admitted	Number 65+ admitted
1981 - 82	5.03	8,179
1982 - 83		8,445
1983 - 84		8,722
1984 - 85		8,993
1985 - 86		9,320

To illustrate the effect of the senior citizen population growth on entry if, this were the only factor affecting enrollment, admissions would grow from 11,685 in 1981 - 82, to 12,826 in 1985 - 86.

Obviously, if the entry rate holds constant, the growth in senior citizen population by itself will have only a small impact on admissions. It is however, likely that because of increased local availability of service and awareness of home care by potential applicants, the rate will increase above 5.03%, over the period from now to March 31, 1986. The Manitoba percentage of senior citizens in home care currently stands at 6.2%. Let us assume a growth rate which brings Alberta to that level by 1985 - 86.

Exhibit VI-7. Estimated number of admissions of persons over 65 to CHCP, 1981 - 86

Year	Estimated Provincial % over 65 on CHCP	Estimated number over 65 on CHCP
1982 - 83	5.20	8,730
1983 - 84	5.50	9,537
1984 - 85	5.85	10,459
1985 - 86	6.20	11,488

We would expect that without any change to ME_1, the percentage of entrants over 65 will continue to slowly increase. If this percentage does reach the Manitoba level, it will mean an increase of no less than 2,500 - 3,000 additional entrants over 65 in the next five years. These entrants will be predominantly female; and increasingly over 75 and without a spouse. Without assuming any change to ME_1 this group will be a main source of increased entry pressure.

F. IMPLICATIONS OF "NO CHANGE"

1. Admissions

Alberta CHCP is still in its developmental stages. Growth in admissions can be expected even if no change is made to the entry criteria. This growth will result from increased public awareness about and understanding of the program, greater local availability of services, population increases and demographic changes.

For the first full year of CHCP's operation - 1979/1980 - admissions were 9,155. For 1980 - 81, the second full fiscal year, admissions reached 11,685. This was an increase of 27.6%. Average monthly admissions increases for the last six months of this period exceeded those over the first six months by 33.6%. Admissions for January and February 1981 (the last two months available) averaged 1,015; compared to 854 for January and February, 1980. This was an 18.8% increase. Indeed, January 1981 had more admissions than any other single month, for which figures were reviewed since CHCP began. Judging by this, admissions are increasing at an increasing rate without any change to ME_1.

The experience of other provinces may be of interest in estimating the maximum potential demand for entry into CHCP. Previous analysis indicated that the British Columbia program has the highest entry rate, followed at some distance by Ontario. Ontario's program up until now has been essentially acute in orientation; but as it adds more chronic care it will undergo rapid growth which will no doubt bring its already high entry rate much closer to that of British Columbia's. For planning purposes, Toronto is estimating that chronic care admissions will average 50% of expected acute care cases in the first year of the changed entry rules.

As a percentage of their total provincial populations, 1979 - 1980 home care admissions varied considerably. (Exhibit VI-8)

EXHIBIT VI - 8. Home care admissions as a percentage of provincial populations, 1979 - 80

British Columbia	2.01%
Ontario	.916%
Saskatchewan	.803%
Manitoba	.796%
Alberta	.451%

Projecting the British Columbia entry rate onto the Alberta population would give a 1979 CHCP admissions figure of 41,000. This level of entry is possibly the result of the fact that the B.C. program began 40 years ago. It is reasonable to assume that in the foreseeable future a fully mature CHCP with ME_1 in place would not reach this figure under any conceivable level of funding.

Projecting the more recent Ontario program's entry rate on the Alberta population gives an admission figure of 22,123. Adjusting for the estimated effect of the new chronic care system brings this figure to 26,200.

The formal Alberta and Ontario entry criteria and delivery systems are quite similar. But as we have seen, the Alberta and Manitoba programs, while having less consistent entry rules, do have apparent similarities in their caseloads. If the Manitoba entry rate were in effect in Alberta, it would have produced 16,100 admissions in 1979 - 80.

Using the experience of other provinces indicates that the maximum effective demand for home care in Alberta over the next five years has a base in the range of 16,000 - 26,000 cases per year.

If the Alberta experience parallels that of Manitoba, the rate of growth should start to slow down between the 24th and 36th month of operation; i.e. between now and the end of fiscal 1981 - 82. If it does shortly begin to decline below the 2.1% month over month admissions increase averaged over the 15 most recent months for which figures are available, the impact of changes to ME_1 may be estimated with less risk. For this would suggest that the natural entry ceiling is in the Manitoba range. However, if the average monthly rate of increase in admissions raises above 2.1% a month, then the potential for admissions under the present system is less certain. And so obviously are the estimates of impacts of changes in ME_1. Therefore, it is recommended that month-over-month admissions be closely monitored as close to the end of 1981 - 82 as possible before final decisions on entry changes are made.

There are at least two factors which by themselves would contribute to keeping the ME_1 entry rate toward the lower end of the estimated range. ME_1 will continue to produce Alberta's substantial rejection rate. Precision here is not possible, but as the Alberta rejection rate appears to be somewhat above that of Manitoba or Ontario, we will assume that this reduces the 26,000 ceiling by 10%.

Furthermore, the percentage of Manitoba's population which is over 65 is 46% higher than Alberta's and Ontario's is 24% greater. With the elderly accounting for over 70% of those Alberta entrants, this proportionally smaller pool from which to draw admissions, reduces the natural ceiling by an additional amount. To illustrate the likely effect of this difference, approximately 7,800 of those 1980 admissions to CHCP were from the 65+ category. If Alberta had the same percentage of its population over 65 as Manitoba, this would

have added another 77,000 persons to the over-65 group; from which another 3,700 home care entrants would have come. One way to adjust the range to reflect these differences is to reduce the figures by .68 (the percentage of the 1979 entrants over 65) x the respective figures by which the provincial 65+ populations exceed Alberta's. This reduces the top figure to 22,000 and the bottom one to 13,000. Thus a reasonable estimate would be that over the next five years, effective home care demand in Alberta with ME_1 in place will fall in the range of 13,000 - 22,000 entrants per year. Beyond that, time, demographic factors, public awareness and service availability come increasingly into play.

If the above assumptions are correct, then annual admission should continue to increase but at a decreasing rate.

2. Active caseload

There is a major potential weakness in relying only on estimates of admissions when calculating the impact of change on costs. The Alberta ratio of new admissions to active cases is about 1:5. That is, for every new entrant there are already roughly 5 cases in CHCP. If the ratio of admissions to active cases goes down, this will indicate that the average length of stay in the program is increasing. If length of stay increases occurred even when growth in admissions was stabilizing, the impact on costs would be substantial.

Analysis of active caseload figures indicates that while the active caseload is continuing to grow, the growth rate appears to be slowing down. In 1980, the monthly growth averaged 3.3%. Based on a projected CHCP caseload of 7,091 by March, 1982, monthly growth in active caseload in 1981 will average 2.6%. The monthly average growth rate in active cases, is higher than the growth rate in admissions (2.1% in 1980). If the actual caseload is increasing at a rate greater than the entry rate there can be only one explanation : the average length of stay on the program is getting longer.

Figures from Manitoba, Edmonton and Calgary can be used to estimate what active caseload growth might be as CHCP matures. In Manitoba, the active caseload grew by .85% a month in 1980, while the admission rate actually showed a negative month-over-month average rate of -8.5%. From the month of January to the month of December 1980 the active CHCP caseload grew by 39.2%. The Manitoba annual active caseload growth rate has averaged 9.8% since the new program began. Clearly, the Alberta program's growth is still being affected by such things as increases in services availability and increased public awareness. It has not yet reached its levelling off point.

In 1980, Edmonton in fact had a negative month-over-month active caseload rate increase, i.e. it went down more often than it went up. Edmonton had 1,362 active cases in November, 1980 and is forecasting 1,665 in November, 1982. This is a total increase of 22.24%, or .92% a month overall. For 1982 - 83 the forecast monthly growth is only 1.53%. If this is correct, it suggests that for the Edmonton program, which is one of the oldest in the province, a sustained lower long-term rate has already been reached.

Calgary had 883 active cases in November 1980 and is forecasting 1,594 in November 1982. This is an overall monthly average increase of 3.35%, close to the provincial average. But in 1982 - 83, the monthly average increase is forecast to decline to 1.26%. Together, for the 1982 - 83 fiscal year, Calgary and Edmonton are forecasting a total annual increase of 16.83% or 1.40% a month. In the same period, Alberta East Central Health Unit is forecasting increases averaging 1.2% a month. Based on these figures, the average annual active caseload growth rate could decline to somewhere in the range of 1.1 - 1.4% a month overall, or in the range of 13 - 17% a year during 1982 - 83.

A mature annual growth in the range of 8 - 12% could be reached before the end of the fiscal 1983 - 84. Exhibit VI-9 shows the estimated future active caseload, based on this assumption. If no change is made to ME_1, the active caseload should be over 10,000 cases at a minimum by 1985.

EXHIBIT VI - 9. Normal active caseload growth estimate

Date	Percentage Growth	Active Caseload
March 1982	22.25	7,091
March 1983	17.00	8,300
March 1984	13.25	9,400
March 1985	10.00	10,350

3. Service mix and intensity

a) Types of service received

An analysis of service utilization figures for both calendar 1980 and fiscal 1980 - 81 was undertaken. Nursing, physiotherapy, occupational therapy, personal care, homemaking and homehelp made up 88% of the total service expenditures. These are the services most likely to be impacted by changes in entry of the type under consideration. Consideration will be limited to these.

In 1980 - 81, a total of 94,115 "patients" received service. Exhibit VI-10 summarizes the service distribution for that year. (It should be borne in mind that in this data the CHCP information system defines "patients" as the total number of persons receiving service each month. Some persons, of course, receive service over several months, so are counted more than once.) Nursing is clearly the dominant service. The support services, homemaking, homehelp and personal care, were received by relatively small proportion of the patients.

EXHIBIT VI - 10. CHCP services, 1980 - 81

Service	Percent of total patients receiving service
Nursing	54.4
Homemaking	6.5
Homehelp	6.2
Personal Care	5.7
Physiotherapy	4.8
Occupational Therapy	2.3

b) Intensity of service.

While the majority of patients receive nursing services, the intensity of service is greatest in support services. Exhibit VI-11 displays the average units of service for each service type. Clearly, homemaking and homehelp are provided much more intensively than the entry services.

EXHIBIT VI - 11. Comparison of service intensity

Service	Average units received per patient in 1980 - 81
Homemaking	20.60 hours
Homehelp	11.15 hours
Personal Care	5.08 hours
Nursing	3.80 visits
Physiotherapy	1.58 visits
Occupational Therapy	1.00 visit

c) Analysis.

Without any change to ME_1 we would expect a continued, gradual increase in the receipt and intensity of usage of the support services. Homemaking is already available in all LHA's; and provided without restriction in about 50% of these. Limits on the availability of homehelp are greater; so its use can be expected to grow for a time more rapidly than homemaking, once these restrictions are reduced.

Thus, the number of homehelp recipients will probably rise to reach that already attained by homemaking. But because of the lower average service intensity - which is not expected to change greatly even after restrictions on access are eased - the cost impact of gradually increased homehelp consumption will be small.

With ME_1 we would expect the proportion of patients receiving homemaking or homehelp to grow by an average of no more than 15 - 20% a year. The overall percentage of patients using each service is not likely to exceed 10% before the end of fiscal 1982 - 83.

Personal care is the other area of some natural growth under ME_1. It can be expected to grow at about the homemaker/homehelp rate; or perhaps a bit more quickly. This will depend on decisions concerning the amount of importance to be assigned to personal care, particularly that provided by homemakers, in the future. It would appear, at the moment, that not all local programs give this form of care equal weight.

4. Staffing

The active caseload figures estimated previously can be used to predict the likely staff requirements if no change is made to ME_1. Assuming the proportion of patients receiving each service remains stable and the intensity of service does not change, we can estimate the number of units of service per month required.

Exhibit VI-12 shows the estimated number of patients in the active caseload. Exhibit VI-13 shows the predicted increases in monthly staff hours by service type. If no change is made to ME_1, staff will be needed to provide for an increase of at least 46% in service requirements, for each service type by 1985. The increase in patients receiving support services, however, appears to be more rapid than for other services. If this is the case, requirements of homemaker, homehelp and personal service may exceed this figure.

EXHIBIT VI - 12. Estimated service distribution in active caseload

	# of patients			
Service	1982	1983	1984	1985
Nursing	5105	5984	6777	7587
Homemaking	460	539	611	772
Homehelp	439	514	582	668
Personal Care	404	473	535	564
Physiotherapy	340	398	451	496
Occupational therapy	163	190	216	238
Total	6911	8048	9172	10350

EXHIBIT VI - 13. Required units of service

Service	1982	1983	1984	1985
Nursing[1]	14804	17353	19653	21639
Homemaking[2]	9476	11103	12586	13843
Homehelp[2]	4917	5756	6518	7179
Personal care[2]	2060	2412	2968	3003
Physiotherapy[1]	544	636	721	793
Occupational therapy[1]	163	190	216	238

1. Units of care -- visits
2. Units of care -- hours

5. Costs

Exhibit VI - 14 shows the average unit of service cost and average case cost for CHCP services in 1980 - 81.

EXHIBIT VI-14. Service and case costs

Service	Average Service Unit Costs in 1980-81	Average Case Cost
Homemaking	$6.84/hour	$141.02
Physiotherapy*	$58.20/visit	92.00
Homehelp	$6.73/hour	75.04
Occupational therapy*	$59.14/visit	53.55
Nursing	$16.64/visit	62.89
Personal Care	$7.95/hour	40.37

*The per unit costs for the therapies are apparently distorted by the under-reporting of visits; which in the case of occupational therapy was recorded as less than the number of patients. Too, the smaller size of the numbers probably contributed to the resulting problem.

CHCP staff expect hourly service costs for some types of services to increase more rapidly than for others. CHCP projections are shown in Exhibit VI-15.

EXHIBIT VI-15. Projected average service unit costs

	1980 - 81	1981 - 82	1982 - 83	Percentage average annual increase
Nursing	$16.64	$15.89	$19.83	10.14
Physiotherapy		$19.10	$20.37	6.64
Occupational therapy		$19.46	$21.02	8.01
Homemaking	$6.84	$ 8.97	$ 9.91	20.80
Personal Care	$7.95	$ 8.67	$10.08	12.65

Source: For 1980 - 81, these are the actual costs as reported by the CHCP MIS system. For the two subsequent years, the figures are from the unadjusted LHA budget requests. The probable reason why the 1980-81 nursing figure exceeds the 1981 - 82 figure is because the average reflects the actual number of visits, including the LHA's with higher unit costs and higher volumes. In the 1982-82 and 1982-83 figures, the average gives equal weight to each LHA. The range, it should be rated is from $16.20 (Wetoka) to $32.50 (Stony Plan-Lac St. Anne) for 82 - 83.

Homemaking has the greatest percentage increase, followed by personal care. This is without any change in entry.

G. IMPLICATIONS OF "LEAVE ME, INTACT, ADDING MORE THERAPY AND SUPPORT SERVICES"

1. Admissions

The impact of this option on the entry rate will be relatively small. The most evident effect will be to make eligible persons previously turned away because an entry service they needed was unavailable. An interpretation of eligibility study data indicates this would add some 100 or so additional entrants annually.

Except for this group of persons, no one else is formally made eligible by this change. Of course, knowledge of the increasing availability of therapy and support service will begin to attract some number of additional applicants. The extent of this will largely depend upon the level of additional funding individual LHA's receive. In particular, decisions about the services on which it is spent locally; and the degree to which it is used to make service available in sub offices and areas not presently served or goals to reduce restrictions on service in areas already served, are crucial. That will largely determine the degree to which its primary effect is to provide more services to current entrants or to serve new patients. No doubt this will vary from region to region. We understand these to be local administrative decisions.

2. Active caseload

This is a function of both the rate of intake and the rate of discharge. As we have seen, direct intake will probably be affected only marginally by this option. However, with increased rehabilitation and support services, length of stay can be expected to increase. The discharge rate will decrease relative to the intake rate.

The impact will be in the direction of an increasing active caseload to admissions ratio. The size of this growth will, as noted, be almost entirely a function of the funding and expenditure decisions.

Manitoba presently offers the level and intensity of therapy and support services covered by this option. To illustrate the possible size of the impact, in 1980, the Alberta admissions to active cases ratio of 1:5 compared to a Manitoba rate of 1:13. While Manitoba's monthly admission rate is 25% smaller than Alberta's, its active caseload is 100% larger.

A decision to fund therapy and support services provision by an amount substantially above the incremental growth rate in funding carries with it the potential of reversing the present decline in the active caseload growth rate.

3. Service mix and intensity

Again, the level of additional funding and local expenditures patterns will be the determining factors.

Administrative steps encouraging the expenditure of the bulk of additional funds on extending service to sub-office areas not presently covered would:

- likely result in a service mix quite similar to that already reported for areas with service,
- have the greater impact on the number of admissions,
- have little effect on the average intensity of consumption.

Conversely, if the bulk of additional funding goes to already established areas:

- The number of additional entrants would be smaller.
- The impact on service mix would be relatively greater.
- The impact on intensity of consumption would be relatively greater.

4. Staff requirements impact

This is a matter of choice. No particular level of additional staffing is inherent in this option. The need is dependant on the level of funds made available and the local perception of service need.

5. Costs

The annual direct program cost of providing service to the 100 or so additional admissions as a result of the wider availability of entry services would not exceed $75,000. Beyond that, additional first year costs are a matter of choice.

The comparative data suggesting the possibility that some current entrants would also benefit from a higher level of support services were noted above. Management's position on this matter is relevant to its decision about the relative allocation of 1982 - 83 program dollars to serviced and under-serviced regions and sub-offices. That is, more money would be allocated to areas with less support service.

H. IMPLICATIONS OF ME_2

1. Admissions

ME_2 would entitle to home care persons with a definite medical condition who have a resulting need for a support service to overcome a threat to their ability to function independently.

A good many of those entitled by ME_2 would be the young physically disabled, the mentally retarded and the frail elderly. The impact on admissions would depend in part on a) the definition of "medical condition" and b) the number of support services included as entry services.

We shall assume for ME_2 the same means for determining the existence of a medical condition as with ME_1; that is, a physician's certification.

"Support services" will be limited to homemaking, homehelp and personal care from a homemaker.

No figures are available on the number of persons in Alberta at risk of insititutional placement because of a medical condition.

Manitoba, however, has been admitting persons to home care on just such grounds since 1974. One way to estimate the impact of ME_2 on admissions, therefore, is to take their effective demand rate, adjust it for the obvious differences between the two provinces, and apply it to the Alberta population. This approach is assisted by sociological similarities between two prairie provinces and by the apparent similarities in the age, sex and diagnostic categorization of the current home care caseloads.

The delivery systems also have some parallels, being centered on field service delivery units providing services on behalf of the social services and community health departments. Major urban hospitals are closely linked to both programs, as are regional public health staff.

In 1980, Manitoba's home care admissions were .0084 of its total provincial population; while home care admissions represented .0053 of Alberta's population. The Manitoba figure has been relatively stable for some time. Were Alberta's annual 1980 admissions at the Manitoba rate, they would have numbered 17,576, 72.6% above the actual figure.

Manitoba's population over 65 is 46% higher than Alberta's; while their percentage of aged home care entrants is roughly identical. On the other hand, there is some reason to believe, based on provincial entry figures presented earlier, and other indications, that medical model programs have a somewhat higher admissions potential than the more socially-oriented Manitoba system. We have therefore assumed that these two factors: higher percentage of aged in Manitoba and greater reliance on medical judgements in Alberta, cancel each other out.

Therefore, in 1980 base figures, the adoption of ME_2 could be said to carry with it the potential for an additional 6,500 entrants.[2] That is: 17,600 - 11,100 (the number actually admitted to CHCP in 1980), who would present themselves for admission to CHCP, one or more times. This figure is close to an estimate of an additional 7,050 persons who would enter CHCP by March 31, 1985 if the need for social support for those with medical conditions was established as grounds for entry. This estimate was prepared in 1980 by the Department's Research and Planning Branch.

2. Active Caseload

ME_2 would admit a significant number of largely long-stay patients. In many cases[2] the physical problems causing the functional dependence would be permanent. The effect would be to substantially lengthen the average stay.

The most recent data provided from the CHCP MIS system indicates 10,459 active cases discharged during calendar 1980. Their actual length of stay is shown in Exhibit VI-16.

EXHIBIT VI-16. Length of stay in CHCP

	Length of stay							
Days:	1-14	15-31	32-61	62-93	94-124	125-155	156-186	187+
No. of persons	1660	1705	1905	1281	770	560	408	2170
Percentage discharged in each period	15.9	16.3	18.2	12.2	7.4	5.3	3.9	20.7

About one-third of the patients are discharged in a month or less. Half are gone by the end of two months; and almost two-thirds by the end of the third month. After 90 days only a little over one-third of the entrants are left on the program.

Manitoba's entry rules strongly resemble ME_2. Therefore, its experience with length of stay and active caseload would be of considerable value in estimating the effect of ME_2 on length of stay. Unfortunately, these data are not collected by the regular Manitoba reporting system. Therefore, a less direct analysis is necessary.

The Alberta and Manitoba admissions to discharge rates from 1980 are quite similar: admissions are 118% and 114% respectively, of discharges. But while the ratios of entry to exit are close, the ratios of caseload to entry and exit are quite dissimilar.

Alberta's 1980 admissions were 2.3 times higher than its active caseload; while its discharges were almost 2.0 times the caseload. But in Manitoba, admissions were only .92 of the active caseload; and discharges were .81 of the caseload.

So although proportionally similar numbers are arriving at and departing from each program, Manitoba's average caseload was almost twice the size of Alberta's. This can only be accounted for by a substantial number of persons remaining on the Manitoba program for indefinite periods.

The Manitoba program director, while declining to make any estimate of the average length of stay, did suggest that some people have been on the program since it began in 1974; and a number of others are known to have been on for "two - three years". There is no limit on length of stay.

If Alberta were to adopt ME_2, there would be an active caseload increase disproportionately larger than the level of admissions increase encountered.

We would estimate that, at a minimum, the active caseload increase would exceed the admission increase from ME_2 by a factor of .75. That is, the average entrant newly entitled by the adoption of ME_2 would be on the program at least seventy-five percent longer than the average entrant admitted by ME_1. The average new entrant, rather than being discharged after not more than 60 days, could remain on for 85 days or more.

The number of new admissions from ME_2 has been estimated in the range of 6,500. While the entry of this group would have a number of effects, the principle one would be the creation of a substantial core group of more or less permanent recipients of home care.

No precise forecast is possible, but a reasonable guess would be that easily as many as half of this group - and especially those under 65 - could remain on CHCP indefinitely, unless administrative action was taken to prevent this.

3. Service mix and intensity

The maximum number of persons who by 1985 will seek admission to CHCP as a result of the adoption of ME_2 is estimated at 6,500.

We will assume that, in their service needs, this group will roughly resemble current entrants into the Manitoba program.

EXHIBIT VI-17. Estimated service needs of ME_2 entrants

Service	Percentage of Entrants Receiving Service	Number
Nursing	40	2,600
Homemaking	65	4,225
Homehelp	55	3,575
Personal Care	25	1,625
Physiotherapy	6	390
Occupational therapy	3.5	260

There will be a very significant shift in the kind of services being requested, relative to that currently being received by CHCP entrants.

For this group of new entrants:

- Nursing recipients will decline by a factor of .27
- Homemaking recipients will increase by a factor of 9.0
- Homehelp recipients will increase by a factor of 7.9

- Personal care recipients will increase by a factor of 3.5
- Physiotherapy recipients will increase by a factor of 2.5
- Occupational therapy recipients will increase by a factor of 5.

As to the intensity of usage, this should not exceed that currently being experienced by urban entrants in Manitoba. Therefore, to estimate the cost of ME_2 we have used the 1982 - 83 projected service CHCP unit costs and the amount of service per entrant actually received by home care recipients in Winnipeg in 1980. We would expect that intensity will rapidly rise toward the figures given below between the time of implementation and 1985 - 86.

This will mean: -

- An increase of up to 38% in the number of hours of homemaking received per patient, over that now going to patients under ME_1. (20.6 to 28.4 hours)
- An increase in the number of homemaking hours by 79% (11.15 to 20).
- An increase in the number of nursing visits of 21% (3.8 to 4.6 visits).
- An increase in physiotherapy visits per patient by 121% (1.58 to 3.5 visits).
- An increase in the number of occupational therapy visits by 200% (1 visit to 3 visits).
- An increase in the number of personal care hours by 100% (5 to 10 hours).

4. Costs

These can be calculated by using the estimated number of additional recipients, service intensity, and the cost per unit of service. In 1982 - 83, the impact for ME_2 would be to add the following costs to the program. This cost would only be reached, of course, when all 6,500 entrants had enrolled.

- Nursing - 2,600 recipients at 4.6 visits x $19.83 per visit = $237,166.
- Homemaking - 4,225 recipients getting 28.4 hours each, at $9.91 per hour = $1,189,100.
- Homehelp - 3,575 recipients getting 20 hours each at $9.91 per hour = $708,565.
- Physiotherapy - 390 new entrants getting 3.5 visits at $20.37 each = $27,805.
- Occupational therapy - 260 new entrants getting 3 visits at $21.02 per visit = $16,395.
- Personal care - 1,625 recipients getting 10 hours of care each at $10.08 per hour = $163,800.

ME_2 is estimated, in 1982 service unit dollars, to have the potential to add approximately $2.34 million to the annual cost of CHCP for newly entitled persons.

This, of course is exclusive of the added cost of providing additional support services to entrants already eligible under ME_1.

Exhibit VI-18 shows the actual per capita expenditure on home care for each province in 1979 - 80.

EXHIBIT VI-18. Actual Provincial per capita expenditures (divided by Provincial population) for 1979 - 80

Manitoba	$8.10
Saskatchewan	$6.63
Ontario	$4.08
B.C.	$3.60
Alberta	$3.53

We assume that, once a suitable adjustment had been made for the smaller percentage of senior citizens it has, Alberta's per capita cost for the adoption of ME_2 would increase over time to roughly the same as Manitoba's.

For 1980 - 81, the estimated per capita figures for Alberta and Manitoba are $5.11 and $10.88 respectively (neither expenditure figure is final).

The Manitoba per capita figure was then reduced by a factor of 31.4 to reflect the fact that Alberta's senior citizens, which make up 68.3 percent of entrants, come from a senior citizen population which is 46% smaller than Manitoba's (68.3 x 46.0 = 31.4) as a % of provincial population.

This gives an adjusted Manitoba per capita figure of $7.47. In 1980 - 81 this would have meant an Alberta expenditure of $15,757,500 as compared to the real expenditure of roughly $10,800,000. This is a difference of $4,957,500. Subtracting from this the $2.3 million estimated cost of new entrants under ME_2, gives $2,617,000.

We would, therefore conclude that the cost of new entrants and the added support service consumption of those already eligible to enter are roughly equal.

Therefore, the total annual program service cost of the adoption of ME_2 would be in the range of $4.5 - $5.5 million, once the full effect of the change was felt. Estimating the additional administrative costs at 20% would bring the total annual incremental cost of ME_2, in 1982 - 83 service unit dollars, to about $6 million.

5. Staffing

To estimate the additional staff required as a result of ME_2, the following output per person is assumed (all are exclusive of travel time).

- Nursing - 5 patient visits a day.
- Homemaking, homehelp and personal care - 65 hours per month (part time).
- Physio and occupational therapy - 3 patient visits a day.

For new ME_2 entrants, additional staff would be required to provide annually:

- 12,000 nursing visits
- 120,000 hours of homemaking
- 72,000 hours of homehelp
- 1,400 physiotherapy visits
- 800 occupational therapy visits
- 16,250 hours of personal care.

This would require:

- 12 nurses
- 165 homemakers
- 100 homehelp aides
- 4 - 5 physiotherapists
- 2 - 3 occupational therapists
- 24 personal care aides

So to meet the increased demand for service from presently entitled entrants under ME_1 and ME_2 would require an additional staff component of:

- 24 nurses
- 330 homemakers
- 200 homehelp aides
- 8- 10 physiotherapists
- 4 - 6 occupational therapists
- 48 personal care aides

No allowance has been made here for supervisory staff.

VII

RECOMMENDATIONS FOR THE FUTURE OF ME_1

1. ME_1 should be modified

The entry criteria should either be narrowed, to admit only those with specific short-term, medical problems and no need for support services; or extended to formally encompass those for whose primary need is for assistance in coping with the functional restrictions imposed by a medical problem.

2. Given the presence of a substantial number of persons already receiving CHCP who have support needs, the future restriction of entry is problematic.

3. Therefore, ME_2 should be adopted, but in a series of carefully planned steps

4. Implementation Preparations should include:

- Extremely close assessment of month by month admissions rate and length of stay changes since April 1, 1981 to assist in making accurate cost and manpower estimates.

- As a step prior to implementation of entry changes, the expansion of homemaking, homehelp and personal care by homemakers; with first priority going to sub-office areas not now serviced.

- This program should be in effect for at least six months before any changes are made to ME_1.

Steps to recruit and retain needed support service staff.

- A guarantee of a minimum number of hours of employment a year. This can be negotiated on a person-by-person basis. It will provide the care provider with an annual income guarantee overcoming the uncertainty usually associated with casual employment. It could also have the effect of increasing provider reliability.

- To hold down costs and ease the problems of recruitment, more use could be made of auxiliary nursing staff and of homemakers or homehelp staff to do personal care

- Creation of a province-wide pension plan for all homemakers/ homehelpers providing more than, say 1,000 hours of service a year. This could be either contributory or non-contributory. But either way it would tend to tie homemakers more closely to the job over time by giving an incentive both to work at least a minimum number of hours and to keep working year after year. A minimum of say, three years would be required before benefits could be paid out. Typically, most females taking such employment have no pension plan. It might be possible for homecare staff to join an existing pension plan such as that offered to hospital staff.

- Seniority bonuses. These would be tied to the number of hours worked rather than the number of years.

- Salary differentials for those providing personal care.

- Special financial assistance with entrance into courses for registered nursing assistants.

- The creation of a homemaker certification program. This would require both the completion of a formal course and successful on-the-job supervision. Certification would not be a requirement, but would result in an hourly premium.

► Development and implementation over the same period of a functional assessment system as part of the eligibility assessment process. A number of these have been developed and are available for review. They include:

a. DMS-1 developed by the state of New York and refined in conjunction with Abt Associates of Cambridge, Massachusetts (See Appendix).

b. The Manitoba Home Care Assessment form which has been proven in use and is widely regarded. Its developers claim its validity and reliability have been proven (also attached).

c. OARS, developed by the Duke University Centre for the Study of Aging and Human Development. This is widely used in the United States and in Saskatchewan. Each instrument has particular strengths and weaknesses; and all require evaluation and probably adjustment to local circumstances.

The objective is to make entry decisions on the basis of:

- An objective evaluation of the applicant's current, and probable future level of functioning if there is no intervention.

- Projection of the impact of alternative service combinations on the functional states.

- Identification of the service mix and intensity having the optimal impact on functional capacity.

- Pre-entry costing of the delivery of this service plan to attain the preferred outcome.

Generally speaking, the greater the extent of impairment, the greater the number of home care services required. And of course as age increases, so does the probability of the need for multiple services. Therefore, such a functional assessment tool is of particular value to any program permitting entry to those with major impairments and those over 75, as does CHCP.

More importantly, entry can be based on estimates of a) probability of the achievement of whatever treatment goals are sanctioned by policy, b) the cost of achieving those goals and c) manpower requirements.

This is an alternative to structuring admission by more categorized criteria such as the presence or absence of the need for any particular service.

By designating a specific acceptable range of impairment (minima and maxima); or by requiring an assessed probability for the achievement of functional goals some percentage of the young physically disabled now excluded, could be safely admitted. The presence of a system for making pre-entry estimates of costs and manpower requirements would reduce the risk of effective demand for the service getting out of hand. Over time, with experience about the actual level of demand from specific groups, the functional exclusion could be reduced.

5. <u>The Introduction of Additional Entry Services Should be Staged</u>

To avoid undue staffing and supervisory pressures, consideration should be given to phasing these in by:

- First introducing homemaking as an entry service. In turn, this could be done on a region by region basis, depending on the local success with the increased service suggested in recommendation Three, rather than introduced province-wide.

- Homehelp and possibly, personal care and meals could be added later, with the timing to be determined by the time required to fully achieve wide availability of homemaking; and by budgetary and staffing considerations.

6. Publicity about the entry rule change should be delayed until staffing capacity has been developed.

7. At a later date, consideration could be given to replacing the physician's certification of need with the functional assessment, for those cases where no active medical treatment is required.

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ALBERTA CO-ORDINATED HOME CARE PROGRAM - ENTRY STUDY

Appendices

APPENDICES

A. Interview Protocol

B. Ontario Site Visit Report -
Dr. E.L. Weinstein

C. Manitoba Site Visit Report -
Dr. R.S. Hikel

D. Saskatchewan Site Visit Report -
Dr. E.L. Weinstein

E. British Columbia Site Visit Report -
Dr. Colin Meredith

APPENDIX A

HOME CARE PROTOCOL

I. OBJECTIVES

a) What are the major objectives of your home care (HC) program?

- What other objectives does the program have?
- How well are your objectives being met?
- How are you measuring the achievement of your objectives?
- Which objectives are legislated?
- Were the objectives developed before the program began?
- How have your objectives changed since the beginning of the home care program (HCP)?
- What led you to make these changes?
- What changes in your program objectives do you foresee in the next few years?
- What problems or pressures are moving you toward new objectives?

b) Was the HCP in your province intended to add to your array of available services, or to substitute for existing institutional services where possible?

-- if additive or both, ask --

- Which services did your program introduce that had not been available before from another program?
- What evidence led you to believe that there was a need for these HC services?
- What services have been added to the program since its inception?

-- if substitute or both, ask --

- What types of institutions or institutional care was it designed to replace?

- Has replacement occurred uniformly across the province or are there regional or urban-rural differences?

c) What specific groups of people is your HC program primarily designed to help?

- What other groups of people does your program address?

- What did these people do before your program was available?

- What unexpected groups have benefitted from your HC program?

-- if not already answered, ask: --

- Was your HCP designed with particular age or income groups as a primary target? What about particular patient types -- palliative, chronic, long-term, acute, post-partum, rehabilitation?

- Does your program specifically tackle the differing gaps in urban and rural health care services?

II. PROGRAM STRUCTURE [If documentation is available on this, skip as much of a & b as possible.]

a) What types of service are offered in your HCP?

- Can you define each of these broad types of service precisely?
- [State broad category and ask] "How do you define ____ services?

-- within each broad category, ask --

- What particular types of service are included in your ____ service category?
- How do you define this service?

b) According to the Act which created your HCP ...

- Which services are mandatory in all areas of the province? To health authorities? To participants?
- Which services are optional?

c) What types of staff are allowed to decide whether a potential client should receive home care services? [See List of Professionals]

- Who decides which services a client should receive [See List of Professionals].
- What sources of referral does your program recognize?

List of Professionals

- Doctors?
- Nurses?
- Other health care professionals?

- ▸ Social workers?
- ▸ Relatives?
- ▸ Others?

d) What types of personnel does the HCP use to provide services? [Fill in the shell from available documentation, if possible -- then skip P.D.]

- ▸ [if not mentioned] Do you also use volunteers?

-- for each staffing category, including volunteers, ask: --

- ▸ What level and type of training or education is required for _____ in your HCP?
- ▸ What services can _____ provide in your HCP? What do they typically provide?
- ▸ How many _____ in total are used in your HCP? [Except for volunteers; ask:] On staff? Contracted?

e) Would you describe your HCP as centralized or decentralized in its administration?

- ▸ What decisions are local authorities allowed to make?
- ▸ Can local authorities choose the services they will offer?
  - Do you have any documentation on which services are offered?
  - Which service offerings tend to differ on a regional or urban/rural basis?
- ▸ Can local authorities modify the eligibility requirements, making them higher or lower, as they choose?

f) What information are local HCP units required to report back to the central agency?

g) What type of Management Information System do you use for keeping track of your program records?

- ► Who is responsible for reporting on local operations?
- ► What information do they report?
- ► How consistently do people use your reporting categories?
- ► Are people reporting on as much as they should, ie:, are reports accurate and on every body [including program rejects]?
- ► How do you foster compliance with your reporting requests?

h) How do you regulate HCP budgeting at the local level?

- ► Do you award block grants or review line item budgets?
- ► What basis do you use to decide how much money local authorities will receive?

i) Do municipalities provide any funding for your HCP?

- ► What services do they fund wholly or partially?
- ► What rights does this give them?

III. SERVICE ISSUES

a) What other agencies [if any] offer similar or complementary services to those offered in your HCP?

- Which services are offered by which other agencies? Within your Ministry? In other Ministries?
- How do these services fit into your provincial health and social service structures?
- How do you liaise with these other agencies in order to coordinate services?
- Is this liaison legislated, part of government structure or informal?
- Do any of these other agencies have different eligibility requirements for receiving services which you also offer?
- To what extent do clients move around between these agencies? How are shifts handled?

b) To what extent are HC services contracted out to non-staff professionals or other private agencies?

- Who decides whether services should be contracted?
- What policies guide the contracting-out of services?
- What percentage of your budget goes for payments to outside contractors?

IV. ELIGIBILITY

a) How [mechanically] is eligibility assessed:

- By whom?
- Where [obtain sample forms]

b) What are the criteria for acceptance into your home care program?

- [If not mentioned] Are there age, income or other non-medical criteria?

c) Have the criteria been altered since your home care program was initiated? How, why and with what effect?

d) Are these criteria consistent across the province or can local agencies vary them? If yes, on what basis are they varied? Do you have any documentation available on the variations in local criteria?

e) Are the eligibility criteria in any part of your province, based on the amount of services and the length of time someone will require HC?

- Is HC to clients limited in any areas to a particular service intensity, time period or cost of services?

f) For what period of time is eligibility granted? Is there a mechanism for periodic reassessment of eligibility? Describe, including time parameters.

g) On what basis are applications for home care rejected? Are statistics available on:

- Numbers of rejections by reason for rejection.
- What other services [if any] are used by rejected applicants e.g., institutional care, no care.

V. SERVICE UTILIZATION

a) For each single service and each service combination provided by your home care program please indicate:

- The age breakdown of your clients.
- The sex breakdown of your clients.
- The living context of your clients [alone, with family, etc.]
- The referral sources of your clients.
- The diagnostic categories of your clients.
- The "lengths of stay" of your clients in the program [less than 3 months, 3-6 months, 7-9 months, etc.]
- The treatment outcomes of your clients [death, transfer to hospital, nursing home, etc.].
- How you define each service, each service unit and the cost per unit.
- The service consumption in service units and dollars.

b) To what extent is service use in some areas limited by the availability of trained supervisors, service providers or other resources?

- In what areas?
- What are the limitations and their consequences?
- What, if anything, are you doing to correct this problem?

c) What is the turnover rate for your various types of HC staff?

- Does this vary by area of the province? How?

d) Have you set up any academic training programs to train the people you need?

- How do you recruit or select people for the program?
- What do you teach in the program?

Matrix of Staff Characteristics

Staff Category	Training Level	Services Provided	# of Personnel in Province (or #/1000 pop.)
Doctors			
Nurses			
Home Care Workers			
Social Workers			
Other Health Care Professionals			
Relatives			
Volunteers			
Others			

APPENDIX B

ONTARIO HOME CARE PROGRAMS UNDER THE MINISTRY OF HEALTH (MOH)

1. OBJECTIVES

The Home Care Programs administered by the Ontario Ministry of Health have two major objectives:

1. The provision of care for the patient in the home where this location is appropriate and is in the best interest of the patient's well-being.

2. The avoidance or reduction of costs by patient care by avoiding the need for admission to hospital or other institution or by reducing this length of hospital stay through earlier discharge to Home Care.

These objectives derive largely from the provisions of s.41b of The Health Insurance Act, 1972 (as amended) which is the enactment under which the Programs operate. While these objectives are not explicitly set out in the section, the provisions which lay down the conditions under which payments are to be made for services performed under the scheme clearly contemplate these purposes for the Programs.

Behind the major objectives lie two key considerations: first, the recognition that Home Care tends to stimulate more rapid rehabilitation and recovery of the patient, and second, the expectation that Home Care should provide substantial cost benefits by relieving expensive patient loads in hospitals and by reducing the need for hospital beds.

These broad objectives of the overall Home Care scheme are applicable to both of the programs currently in operation, however, there are important differences in emphasis. The Acute Home Care (AHC) program is designed for short-term care (typically less than one month), and since it involves cases where the prognosis is for recovery in the short-term, rehabilitation is not the overriding concern. Rather, the main consideration in offering the program is the fact that it substitutes for higher-cost institutional care.

For the Chronic Home Care (CHC) program, rehabilitation is the essential basis of the program. For those cases with rehabilitative potential, CHC is available to obviate the need for institutionalization. The rationale here is that home care has at least as good rehabilitative potential and so should be preferred to more expensive institutional care. In short, the fact that home care substitutes for higher-cost institutional care is, in the case of CHC, secondary to the main consideration: CHC is offered where home care will foster rehabilitation at least as well institutional care.

The kinds of institutional care for which CHC and AHC substitute can be to some degree inferred from the prior sites from which cases were referred in 1979-1980. The proportions are as follows:

Exhibit I - 1.

	% of Referrals		
	CHC	AHC	Overall
Active Treatment Hospital	37.3	67.4	65.0
Community	37.3	23.6	24.7
Chronic Hospital	1.9	1.1	1.2
Other Home Care	21.3	0.4	2.1
Nursing Home	0.7	2.7	2.6
Home for the Aged	0.1	1.6	1.5
Rehabilitation	1.4	3.1	3.0

Another major consideration underlying the design of the Programs is the intention to:

> "...assist patients and their families within the varying contexts of private residential living. This includes a utilization of available family resources as a pre-requisite to additional input from the program. In other words, HC should not duplicate existing family potential for home-based support of the patient e.g. "meals-on-wheels", bed baths, housecleaning. Professional services should not be used where lay or support skills only are required. Similarly, support services should not be provided where the family/household members are capable of providing the required support service."

There are also a number of objectives which relate specifically to the scope and operation of the Programs:

- To ensure that Home Care services are available and accessible to residents of Ontario.
- To ensure that individual Home Care Programs operate in an efficient and economical manner.
- To ensure that individual Home Care programs provide an acceptable standard of care.

Not unexpectedly, these do not have any particular legislative basis.

The Ministry has yet to develop and implement an evaluative scheme for these programs, although it does gather and monitor data gathered from the "Ontario Home Care Administration System".

As reference to the criteria for eligibility (set out infra) makes clear, these programs have not been designed to help a closely-defined target group. Eligibility is defined primarily in terms of the needs and the characteristics of the circumstances of each case. The programs are not limited in terms of age or income. Nor do they specify the types of illness/ disease to which the programs extend.

Prior to the introduction of the programs (AHC in 1970; CHC in 1975), patients now eligible under either program would have had to seek to remain or gain admission to one of the various forms of institutional care available; failing that, it would fall to the patient and any community and family resources to provide the care required.

The basic objectives of the Home Care Program appear to have remained unchanged since the inception of AHC in 1970. Even the introduction of CHC in 1975, which marked an extension of the basic scheme to patients with chronic-care needs, involved no change in the objectives.

II. PROGRAM STRUCTURE

The programs are operated at the local community level by the local Boards of Health or other approved agencies under the direction of the Ministry. All costs are paid by the Ministry as a benefit in the Ontario Health Insurance Plan (OHIP). Total financial responsibility lies with the Ministry.

Of the 38 local Home Care Programs, 30 programs are administered by the representative local Boards of Health, 4 are operated by the Victorian Order of Nurses, 1 is operated by the Metropolitan (Toronto) Board, and e by local Hospital Boards.

Administration of Home Care involves the coordination of services including hospital liaison. Local Public Health agency staff are most strategically capable of performing this overall function. Voluntary and institutional agencies have a role to play and are taken into account in the development and provision of various services in the program.

1. Services provided

All services available under the HCP are available province-wide. They are:

- Visiting nursing services;
- Physiotherapy;
- Occupational therapy;
- Speech therapy;
- Social Work services;
- Nutrition counselling;
- Visiting homemakers' services (up to a maximum equivalent of 10 eight-hour day units);
- Drugs, dressings and medical supplies;
- Diagnostic and laboratory services;
- Hospital and sickroom equipment;
- Transportation;
- Meals-on-Wheels.

2. The local administrative agency and its responsibilities

Chief areas of responsibility of the administrative agency are summarized as follows:

- Developing a co-ordinated plan for implementing a detailed program in the local community;
- Applying for Ministerial approval of the plan;
- Appointing a Home Care staff.
- Entering into agreements with local agencies providing service to the program, thus ensuring the provision of the necessary service and determining the rate of payment for which the service will be provided.
- Submission of a budget for the detailed program for approval by the Ministry.

- Maintenance of a satisfactory accounting system.

3. Staff of the Local Home Care Program

The basic staff of a Home Care Program consists of:

a) Medical advisor

Usually a part-time appointment for a practicing physician He works closely with the Home Care Administrator providing an informed input to policy implementation as well as day-to-day application of principles and guidelines. He provides medical consultation to the other professional participants on the Home Care Team, and to the patient's attending physician in regard to individual patient's progress on Home Care.

In specific situations he acts as interpreter to the attending physician on Home Care policy.

b) Home Care Administrator

The Home Care Administrator is a person vested by the Home Care facility with the responsibility for management and supervision of Home Care Services (as defined under Ontario Regulation 989/75,s.1.). Traditionally, in Ontario, this position has been occupied by a nurse, although it is recognized that other health oriented disciplines could successfully meet the requirements of this position. An important component of this position is the management function.

The qualifications required are:

1. Basic qualifications and appropriate to the health profession concerned, and be a member/or in good standing with their profession.

2. Knowledge of community organization and resources.

3. A minimum of 3 years experience in community health service provision.

In cases where appointment of a nurse is considered, the criteria should include:

1. A current certification of competence from the College of Nurses of Ontario.

2. A diploma or degree in Public Health Nursing.

3. Some background in administration and supervision of health services with preference given to those with preparation in business or health administration.

Responsibilities include:

- Administer and co-ordinate services of the Home Care Program;
- Carry out the legislative and administrative policies and guidelines set down by the Ministry of Health, as well as for the monitoring and provision of services under legislation within the budget approved by the Ministry of Health.

The Home Care Administrator is responsible for ensuring:

- Production of appropriate records and statistics;
- In-service education for self and staff;
- Administrative supervision;
- Quality care;
- Cost effectiveness;
- Research.

The Home Care Administrator:

- Interprets the policy and guidelines of a Ministry of Health Home Care Program, as applied to the local area.
- Acts as a public relations officer for the Home Care Program.
- Monitors the cost and quality of service within the Ministry approved budget.
- Is responsible for maintaining professional qualifications and contacts to maintain an up-to-date knowledge.

c) Nurse Liaison(s)

The Home Care Liaison Nurse provides liaison between the Home Care Program, health agencies and other community resources. She provides the co-ordination of health resources in order to assess the needs of the patient, and focus the appropriate available health care services on meeting the person's health needs at home. This is normally a part-time position for hospital-based nurses.

d) Office assistance - usually full-time

The staff is administrative and provides no direct care to the patient unless essential services required by the program are lacking in the area to be served and the Home Care Program has to hire the necessary staff to provide such services.

Normally, all the services required to implement the program such as visiting nursing, homemakers service, physiotherapy, etc., are purchased from community resources.

3. Staff activities

The staff of the Home Care Program is normally engaged in:

- Assessment of patient's needs;
- Evaluation of the home;
- Planning, co-ordinating and arranging for the service required;
- Delivery of care (where not provided by any existing service agencies);
- Evaluation of the patient's progress;
- Reporting to and consulting with the attending physician;
- Adjusting service to meet changing needs of patient;
- Termination of service when indicated.

4. Referrals

The Act specifies that referrals may only be made by medical doctors.

5. Degree of centralization

While the local authorities do have discretion, particularly for eligibility decisions, the Program is structured to provide a good measure of central control. The Ministry must approve such major items as the budget, for instance, local agencies must obtain approval for the purchase of any item or service exceeding 5% of a budget line item. Nor is there really any discretion as to what services are offered, basic eligibility criteria, or the organization of the operation.

Budget is reported monthly, as is the provision of services (see Exhibit B-1).

III. SERVICE ISSUES

MOH and COMSOC both offer homemaker and nursing services. In general the same service providers act for both agencies. The overlap is described in the COMSOC report and is estimated at about 3% of cases. In general the services are complementary and reflect differences in eligibility criteria. An effort is being made to make services mutually exclusive.

Relations between the two Ministry's programs are recent and dealt with by a Joint Task Force. Relations are not always cordial, but they are moving toward a resolution.

IV. ELIGIBILITY

1. Assessment

Eligiblity assessment is the responsibility of the staff of each local Home Care Program. It is carried out by a medical professional, usually a public health nurse, and tends to be a fairly subjective judgement.

The assessment takes place upon written application of the patient's medical doctor. The doctor's referral is required by law. Once the assessment is complete, the local Program advises the Ministry of the outcome (see Exhibit D-1).

2. Criteria

The decision to place any particular patient in a program of Home Care is based upon a consensus view of the staff of the program and the attending physician that such a move is in the best interest of the patient.

EXHIBIT III-1. Report on Service Provided

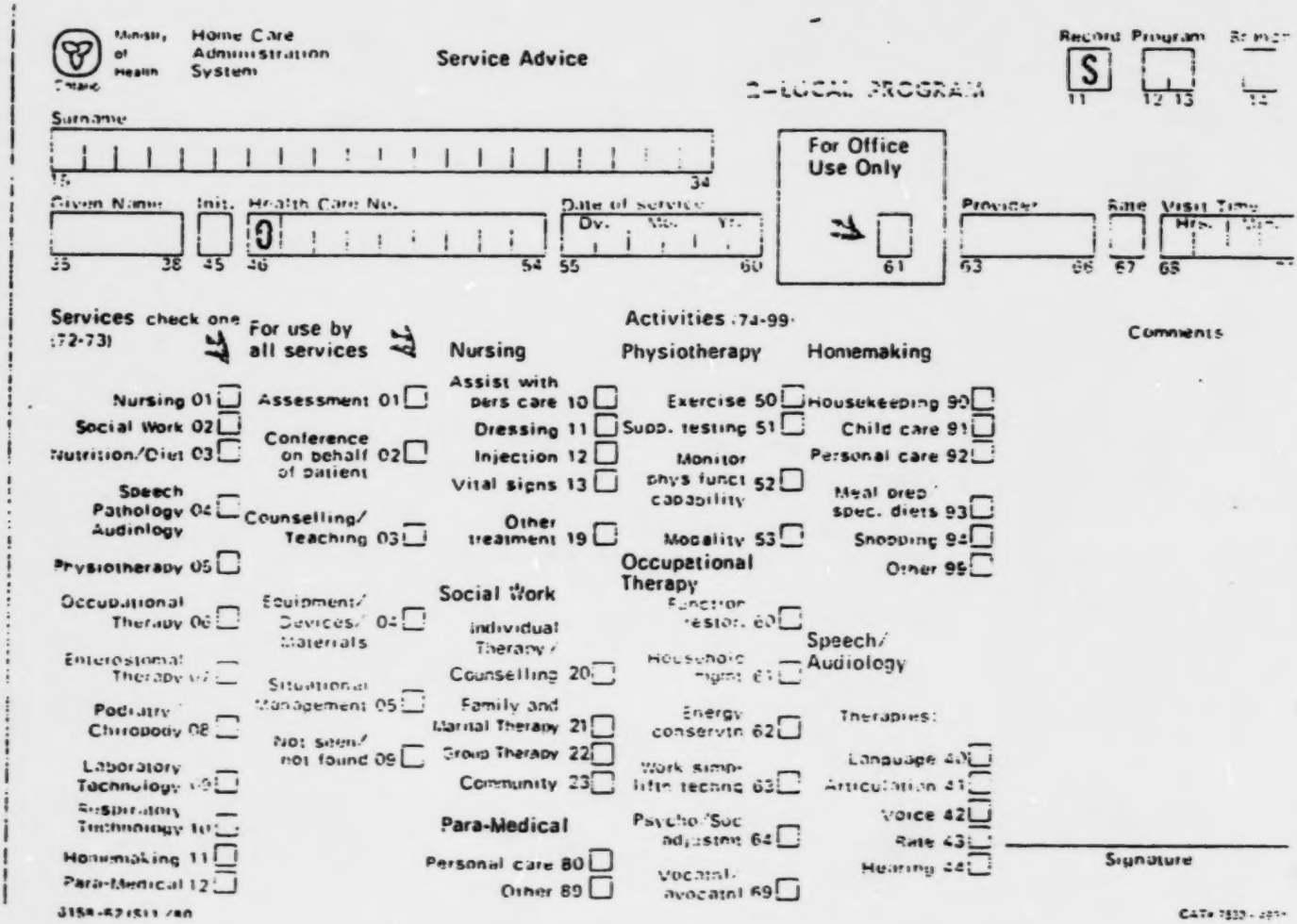
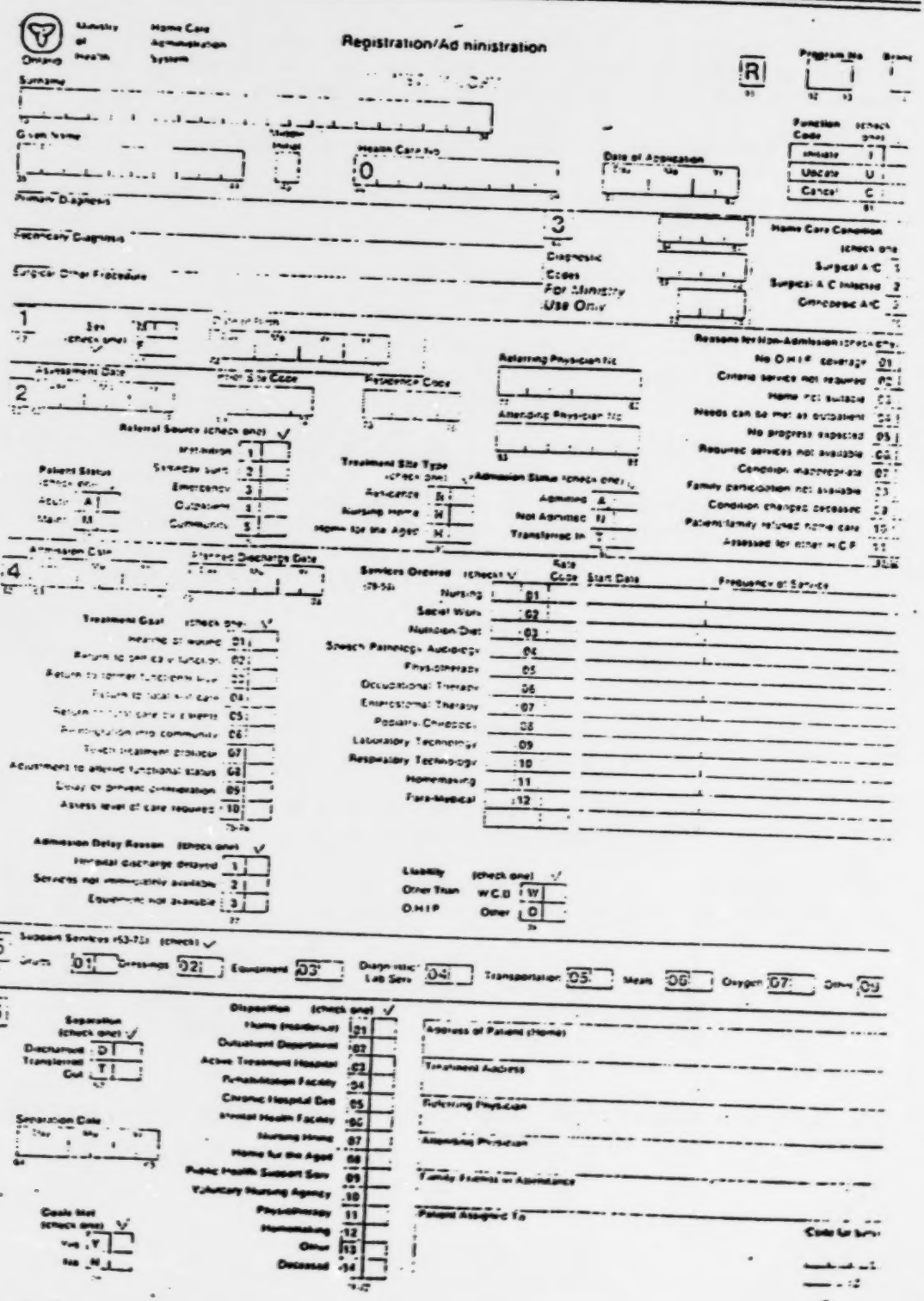


EXHIBIT III-2. Application for Registration/Administration



The Ministry has specified the eligibility criteria on which the determination is to be made.

The Ministry is moving toward merging CHC and AHC, as well as their eligibility criteria. But this has yet to take place, so the two must be dealt with separately to the extent that they differ.

Most eligibility criteria are common to both:

- The patient is insured under the Ontario Health Insurance Plan.
- The patient is under the medical supervision of an attending physician.
- The patient's medical condition is such that he can be treated adequately at home with the services available through the Home Care Program.
- The patient's needs cannot be met on an out-patient basis.
- The patient is in need of at least one of the professional services such as nursing, physiotherpy, occupational therapy, and speech therapy. (Homemaking service does not qualify in the category of a professional service).
- The home is suitable to enable the required care to be given.
- The patient's family is willing and able to participate in the program where and when required.
- The patient resides in the area designated as being covered by the Home Care Program.

The key difference lies in the standards applied to the patient's prognosis. The criterion for AHC reflects that Program's short-term orientation:

- The patient's professional treatment can be expected to result in progress towards the written goals established for rehabilitation. When progress is no longer apparent, the patient is transferred to an alternative, appropriate, mode of care.

Once progress toward the written goals for rehabilitation has stopped, the patient is no longer eligible for AHC.

By contrast, to be and remain eligible for CHC, the patient's professional treatment must be expected to delay or prevent a deterioration in the patient's medical condition or the need for institutional care.

These criteria have province-wide applicability. However, they are subject to interpretation by the various local staffs, so one cannot assume uniformity in actual practice. For instance, each local program has developed its own form to be used by doctors making a referral to the program.

Periodic assessment of the patient's progress includes an assessment of continuing eligibility for Home Care. Changes in the patient's condition, family circumstances or requirements for care may change eligibility for continuation of Home Care. When the goals for rehabilitation established on admission are reached, or when a disease reaches a stable phase, alternative arrangements for care are made in consultation with the attending physician. Where the patient is under AHC, this could include transfer to CHC.

As a general rule, where adequate rehabilitation is expected within a month, the patient is assigned to the AHC program. For periods in excess of one month, CHC applies. During the 1979-80 period, the average length of stay on AHC was 32 days, 126 days on CHC.

For 1979-80, the number of admissions (new and transfers) to CHC was 6,790 and there were 437 applications rejected; AHC had 71,746 admissions, 13,207 rejections.

V. SERVICE UTILIZATION

Most of this information is dealt with in the accompanying Statistical Report. (Document One)

Limitations in service due to personnel shortages are currently experienced for rehabilitative programs due to lack of physiotherapists. This situation is expected to get worse in the near future when other health units come into the program. Nursing shortages are beginning to show up and are also likely to increasingly inhibit service in the future.

Turnover rate has not been investigated.

Training of professionals is under the aegis of the Ministry of Colleges and Universities and not directly affected by MOH concerns alone.

ONTARIO HOME CARE PROGRAMS
UNDER COMMUNITY AND SOCIAL SERVICES (COMSOC)

I. BACKGROUND

1. Two Home Care Programs

Home Care programs in Ontario are offered by both the Ministry of Health (MOH) and the Ministry of Community and Social Services (COMSOC). A separate report has been written for each Ministry since their programs are run independently and liaison is recent and relatively informal.

Relations between these two Ministries are not completely cordial. Based on historical precedent and personnel in each Ministry, they tend to differ on:

- Who should decide on eligibility and care needs -- health care professionals (MOH) versus the service provider (COMSOC).
- Who should be eligible -- those who can be made independent with a temporary array of services (MOH) versus those who require the support to stay at home (COMSOC).
- Payment for service -- no patient fees (MOH) versus client fee for service depending on need (COMSOC).

In addition, there are some philosophical differences arising out of the differing philosphies of the two Ministries.

As a result, we report on the two Ministries separately. The cumbersome effort of joining their programs and separating them constantly in text seemed a poor strategy. This paper deals with the COMSOC program.

2. The protocol

Prior to meeting with COMSOC staff, they were informed of the topics to be covered in the interview. As a result, they made available the accompanying documentation labelled "Ontario - COMSOC Programs". The programs are listed here from highest to lowest dollar expenditure. The detailed description of each program answers most of the questions in the protocol. Additional questions, answered in the interview, are discussed in subsequent sections. (Document Two)

II. Program structure

COMSOC home care programs (HCP) are all run by the social service agencies of each local municipality. Municipalities here are defined broadly and can include indian bands (especially Northern Ontario) and townships (especially Eastern Ontario).

Each HCP receives a different subsidy based on the budget they negotiated with COMSOC. The subsidy (80%-100%) is a monthly reimbursement of operating expenses. Budgets must be reported monthly and receive relatively light scrutiny. In general though, the program has been under-spent since MOH introduced its chronic home care program and a substantial portion of clients switched to MOH.

III. Program services

No services are mandatory under this program. The most commonly offered services are meals-on-wheels, homemaking and home maintenance. Nursing services are offered to those requiring less than 3 visits per month (MOH critiera) and excess nursing service is provided over the first forty hours needed per week (provided by MOH).

Amount of service needed is decided by each service providing agency separately. Despite the potential conflict of interest, COMSOC feels there is little abuse. Concern is only expressed for home maintenance services where high desire can be documented, but criteria for need are unclear.

Services not provided, but in demand, include transportation and home modifications for the handicapped.

There are indeed regional inequities in service with rural areas generally less well served. Rural problems stem from problems of transport for service providers and lack of availability of personnel. In Toronto and Ottawa there are sometimes problems due to movement of trained home-makers into more highly paid jobs.

Fees are charged for all services except nursing and clients pay according to their means. There is a means test used to assess "residual income". This residual income may be charged with fees until it is used up. When clients are unwilling to pay, they tend to refuse the service. If they default on their payments, a rare occurrence, it is the responsibility of the service providing agency to recover it. The "means test" can vary substantially from municipality to municipality.

The fees paid to service providers are negotiated locally, but COMSOC approves all homemaking rates and MOH approves all rates for professional services. Both Ministries use the same fee schedule.

Services are provided by a mixture of private and public agencies. In most communities homemaking is provided through the Red Cross or Visiting Homemakers Association, while churches and volunteer groups tend to provide meals-on-wheels. In Toronto, however, services are provided commercially. In all cases, there are no standards or skill requirements for homemakers.

IV. Eligibility

Each agency makes an independent assessment of a client's needs for its services. Thus, if five services were needed, there might well be five separate needs assessments. In many communities, however, a unified intake service has been formed.

Not only does each agency decide on eligibility, but it also decides on the level and intensity of service it will provide. Since many homemaking agencies are at their service limit, this may be less than desired.

Both eligibility and service intensity must be evaluated on a quarterly basis. Since services are ordered on a monthly basis though, this often becomes the real time for re-assessment.

Clients may be turned down or discontinued from service if:

- They are not deemed to need the service.
- Other family members can do it.
- Services exceed the asset limits of the client.
- The client is too difficult to deal with.

V. ADDITIONAL COMMENTS

A few additional observations worthy of note:

- MOH shows more distrust of COMSOC than vice versa. The joint committee for looking at both their HCP is fledgling with much to do in creating exclusive services. A formal link is needed.
- A system which allows municipal adjustment of means tests tends to result in gross inequities.
- The conflict of interest in the assessment system invites abuse -- whether it is occurring or not.

- The need for a unified intake becomes more apparent in Ontario.

- Each of the three locations visited (MOH, COMSOC, Saskatchewan) is concerned about the flood of demand which would follow adding services. Between them pretty well the full range is offered, and no one has experienced any flood.

REFERENCES

Portions of this report were excerpted from the following MOH documents:

Home Care Planning Team, Report of the Home Care Planning Team, (Draft V, May 1980).

Standards and Guidelines for Home Care Services (Draft; June 1977).

Home Care - Annual Report (April 1, 1978 - March 31, 1979).

Home Care: Ontario - 1981.

APPENDIX C

HOME CARE PROTOCOL

Manitoba Continuing Care Program

I. Objectives

a) The current objectives of the program were set out in April, 1975 shortly after the program began. They have not been changed since then. They are:

- To develop and provide services in the home setting as a viable form of care.
- To develop and provide services as an alternative to institutional care for those for whom care at home is most appropriate.
- To relieve excess stress on family members and, in so doing, prevent the breakdown of a desirable living arrangement and/or the health of the person/persons providing care.
- To prevent the premature, expensive placement or over-stay of persons in care facilities (including hospitals) and thus prevent the over-building and/or over utilization of institutional facilities.
- To continuously evaluate the impact of the program on the target population and other Health Care delivery systems.

Home care is administered as one component of a spectrum of care including nursing homes. It acts to support the assessment and planned placement of persons into nursing homes (Document 1).

The objectives are being met. Two studies, one in October 1975 by the staff of the Management Committee of Cabinet (Document 2) and a later one by the Office of Continuing Care and the Policy, Planning and Information Branch of National Health and Welfare document the achievement of the objectives.

In addition to periodic studies on goal achievement there is an on-going case review system to check compliance with objectives and operating procedures. This review uses a carefully defined set of procedures and standards which are stated in an attached document. It is carried out in each social services region annually.

There is no legislation. None is planned. The program operates on the basis of policy. The program added a respite care service in 1979 - 80; in conjunction with the Manitoba Health Services Commission Nursing Home program. Beds are reserved in nursing homes for use by home care recipients for up to three weeks.

Short-term future plans include both the consolidation of recent changes and increased services for the young disabled living in special residences in Winnipeg. Homemaking and personal care are being provided, on a group basis, to those with very high levels of impairment. This includes quadriplegics. Most of the residents are students or are employed.

A third residence is being built in Winnipeg; as one response to increasing pressure for more of this type of service. Presently there are a total of 28 suites in two separate specially designed facilities.

One of these facilities has 24-hour staff.

The emphasis is on keeping the young disabled out of institutions at all cost.

b) Home Care was set up in the fall of 1974 to take some of the pressure off the growing demand for nursing home beds, which developed following the introduction of a nursing home insurance plan. Substantial nursing home waiting lists then developed. Examination of applicants made it clear many of them could be adequately cared for at home. Thus, the Manitoba program has had the avoidance of unnecessary nursing home placements as a major goal since its inception. It also seeks to replace other forms of institutional care except for acute hospital treatment.

Home care had previously been limited primarily to short-term nursing done by the VON in Winnipeg; limited long- term nursing by public health nurses, and home care for social assistance recipients in the rest of the province.

Three documents - The White Paper on Health Policy (1972), a report of the Provincial Home Care Working Group (1974), and the Manitoba Study on Aging - all indicated a need for home care.

Since the program has begun, a substantial increase in the use of licensed practical nurses and aides/orderly services have been added.

The degree of success the program has had in replacing nursing home care is documented in the federal/provincial study mentioned above.

For 1980, of 8,835 admissions and re-admissions, 43.5% would have remained in the community without appropriate care; 33.2% would have been admitted to or remained in hospital; and 23.3% would otherwise have gone into nursing homes. This pattern is similar to the one found in 1979.

Utilization is more varied from place to place in rural areas. In urban areas the utilization is more uniform across different areas and groups.

c) The Manitoba plan has no special target groups.

By using the regional offices and staff of the department for delivery, a rough equality of urban and rural service availability is assured.

A study done four years ago showed that LPN (Licensed Practical Nurse) service for most home care was better and more acceptable to patients. Manitoba found that regular nurses were over-trained for most home care and as a result were often dissatisfied.

As well, increased provision of personal care by homemakers under the supervision of LPN's or RN's - depending on the needs of the case - has worked well. All LPN's and home care attendants are coordinated by RN's.

These two moves have kept down the cost and rate of increase in nursing utilization.

Homemaking is seen as especially important to avoid wasting the impact of nursing. As well, homemaking is crucial in keeping down nursing home waiting lists.

The number of middle-aged persons on the program is declining:

Age Distribution
of those on Home Care

	1975	1981
0 - 18	2.4%	3.4%
19 - 64	22.3%	20.2%
65+	75.1%	76.4%

The increased number of young disabled benefitting by the program has been a surprise. Growth is occurring because of the initiatives of the disabled themselves.

There has also been an increase in palliative care from 14% to 19% of entrants. This is the result of an increased number of hospital-based palliative centers working closely with home care.

The program is specifically designed to tackle the urban-rural gap by making all services available in rural areas.

II. Program Structure

The program structure includes a provincial home care office in Winnipeg which is part of the Office of Continuing Care. The program is the responsibility of the Director of Continuing Care. This office is responsible for recommending policy, budget and administrative procedures to the relevant Assistant Deputy Minister and for enforcing these once they are established.

The actual service is delivered through a network of agencies. These are:

Rural (outside Winnipeg)

Regional Offices - 7
Health Centres - 5

Urban (Winnipeg)

Long-Term Care - Regional office
Short-Term Care - VON

Children's Hospital
St. Boniface Hospital
Health Science Centre
Municipal Hospitals

The new program made the following services available, more or less evenly across Manitoba:

Household Maintenance	Personnel Providing Service
Meal Preparation	Homemakers (As Appropriate)
Cleaning	
Laundry	
Personal Care and Hygiene	
Assistance in:	
Bathing	
Grooming	Homemaker and/or Aide/Orderly
Feeding	
Dressing	
Health Maintenance Services	
Health Teaching	Public Health Nurse/ Registered Nurse
Surveillance	Public Health Nurse/Registered Nurse/Licensed Practical Nurse
Drugs Care	Registered Nurse/Licensed Practical Nurse/Homemaker
Diet Care	Homemaker/Home Helper
Physical Exercises	Physiotherapist/Homemaker/Aide
Activation	Occupation Therapist/Homemaker/ Aide
Supervision/Social Relief	Sitter Attendant
Foot Care	Registered Nurse/Licensed Practical Nurse
Health Treatment	
Treatment Procedures	Medical Doctor/Public Health Nurse/Registered Nurse
Drug Therapy	Public Health Nurse/Registered Nurse
Diet Therapy	Home Economist/Public Health Nurse
Physiotherapy	Physiotherapist

Health Treatment	Personnel Providing Service
Speech Therapy	Speech Therapist/Public Health Nurse
Occupational Therapy	Occupational Therapist
Information and Referral Counselling	
Income Maintenance	
Financial Counselling	
Resource Counselling	
Legal Counselling	
Personal and Family Social Service	
Personal Counselling	Social Worker
Health Counselling	Public Health Nurse
Mental Health Services	
Facility Services	
Day Hospital	
Hospital Short-Term Relief Care	
Personal Care Home Day Care	
Volunteer Services	
Daily Hello	
Friendly Visiting	
Transportation	
Shopping	Provided by Volunteers
Snow Shovelling *	
Meals on Wheels	
Surveillance	
Equipment Services	
Home Care Equipment	Home Care Equipment Pool
	Other

* As a paid service only if critical to delivery of Home Care Service.

For each region there is a Continuing Care Co-ordinator in overall charge of the program. This person reports to the department's regional director on a daily basis. Specific individuals are regionally responsible for the nursing and homemaking services. Case Coordinators handle case planning and direct the actual providers in each specific case.

According to the policy manual, the regional Continuing Care Co-ordinator; plans the Regional Home Care Program, ensures that appropriate functions are being carried out effectively, maintains the standards of all aspects of service as a shared function with the Regional Director and the Director of Continuing Care, ensures that the data and reporting system are in place and are utilized well, and is responsible for the orientation, evaluation and training of personnel in the Home Care Program. He/she also participates in systematic review of the effectiveness and impact of the Program in conjunction with the Office of Continuing Care and the Regional Director and co-ordinates a systematic review of Regional resources in conjunction with the Home Care staff and the Resources Co-ordinator.

Specific expressions of what homemakers do in the home are contained in detailed job descriptions. Note that Manitoba's homemakers are divided into four classifications: Homemakers I-IV; plus Homemaker Co-ordinators. Job descriptions are also given for home care attendants, LPN's, and nurses. (Document 3).

The home care policy manual contains the list of authorized services and providers given above (Document 4). It also contains a definition of home care; of homemakers, attendants, and volunteers. This manual, which was established in 1975, is now being revised. It will be replaced with two separate manuals; one for managers and one for field delivery staff. Aside from these, there are no written service definitions. The Provincial Director of Nursing provides overall nursing standards; while the senior regional nurse interprets these locally.

The services listed in the policy manual are all mandatory to the extent that delivery staff are available. Services like home maintenance or transportation are seen as supplementary community services. As such, they are not paid for by home care.

Case co-ordinators handle assessments and entry decisions and prescribe the volume and type of service. These people are always registered nurses (B.Sc.N., or Public Health Nurses), or social workers, most of whom are M.S.W.'s. Referrals can come from any source.

Physicians give patient information and advise on care plans; but they do not make admission decisions.

Homemakers are employed on a part-time basis. They hold the status of casual employees of the provincial government. There is, however, a move to have more become full-time.

There are in excess of 20 homemaker co-ordinators in rural areas. They are also hired casually; or on a term basis. They are also part-time employees.

In each region, staff recruiting and development is in the hands of one person. These people are responsible for orientation and training.

The levels of education and training required are reported for each position in the attached job descriptions.

In a typical month, the program employed:

Registered Nurses	103
Licensed Practical Nurses	76
Home care attendants	136
Homemakers	1,682
Volunteers	1,100
Therapists	45

The program is centralized in policy-making and decentralized in delivery.

There are no local authorities in the sense of separate autonomous jurisdictions. The program is delivered by local staff of the department who make all the care decisions. There is no local variation in eligibility.

All data collected locally are reported by the regional co-ordinator on a monthly basis. This is done using a designated form (G5-5-002 Document 4). The dollar costs are reported on a separate automated system.

A statistical summary is produced centrally, according to an established format (Document 6). There is also an annual report in standardized form, with statistical tables (Documents 7 - 16).

The actual reporting is done by a regional clerk. Ultimately, each Regional Director is responsible for compliance with the reporting requirements. He is the senior departmental figure in the region.

Contract agencies such as the VON also are required to comply. All have agreed to do so. Reporting is one major condition of participation in the program.

Municipalities provide no funding for home care and play no part in delivery.

There is one centralized budget which is prepared in Winnipeg by central office staff and submitted to the Deputy Minister for his review, with all other departmental budgets. This is built up from requests from the regions and agencies. Requests are based on past expenditure patterns and current and projected utilization. The money is actually allocated to each region, which is expected to monitor the expenditures. The regional home care coordinators have the assistance of regional administrators. There is central office monitoring of expenditures; and there is an annual review each fall by a central agency of the Finance Department.

If necessary, supplemental appropriations are possible.

III. Service Issues

There are no other home care programs per se creating a danger of overlap. Specialized services may be provided or funded by; a) commercial nursing or homemaking services and b) mental health, child and family services, and public health programs of the department. These programs may provide homemaking or respite care for different reasons. Home Care in fact shares local staff with these agencies. The overlap is small. The region co-ordinates all these services and the home care central office polices the boundaries of the programs. Liaison is the result of the organizational structure of the department.

As to different eligibility, VON short-term care differs slightly from short-term care delivered outside Winnipeg. Also some specialized hospital programs do case management in a way which reflects their needs (Children's Hospital, St. Boniface Hospital, Health Sciences Centre). These and other hospitals also do their own discharge planning. In some there is an over-emphasis on the short-term. They tend to see needs in purely health therapy, post-hospital care terms; with less emphasis on the long-term and rehabilitation.

There is a centralized registry for home care operated by the Office of Continuing Care. Any agency taking on a client checks the registry to see if the person is already on home care. The system uses unique home care numbers. This keeps track of shifts between home care program components.

The only service purchased by home care is home orderly service. This is from a proprietary company. It serves males primarily; especially the severely disabled. It is available only in Winnipeg. Home care is developing its own orderlies in order to set standards and monitor care. Each decision to contract-out is made by the program's head office.

IV. Eligibility

There is a standard assessment form criteria (Documents 17 - 19). N.B. the blue form (Document 17, A2-5-017-MC 91) is being phased out and will be replaced with a version of Document 17 in the fall of 1981. The criteria are:

General Eligibility

Home Care is for persons for whom it is appropriate to continue living at home as follows:

1) Home Care is extended to persons who, with the realistic assistance of family, friends and available community resources, are unable to function adequately to continue to remain at home in the community.

2) Home Care is extended to persons for whom the provision of services will maintain or prevent deterioration of functionning essential to remaining at home in the community.

3) Home Care is extended to persons for whom living in the community is dependent upon services performed by family members and where the provision of Home Care services for relief of these family members will prevent the deterioration of an appropriate home environment.

4) Home Care is extended to persons who, although eligible, and in need of placement, are awaiting an institutional bed.

5) Home Care is extended to persons who, with Home Care services, can be discharged from an acute care facility.

Determining Individual Eligibility for Home Care

1) Eligibility is determined by a total assessment of the person's ability to function in their home environment. This is a professional assessment and includes an assessment of clinical status, health functionning, social functionning and environmental support. The clinical status assessment need not precede initial placement of services.

2) The assessment identified:

a) Those activities/supports basic to household, health, personal and social needs which the person can perform and those which the person cannot, or should not, perform.

b) Those activities/supports which family members or others in the household are performing or could realistically perform.

c) Those activities/support needs which are not being met.

3) The Office of Continuing Care may be consulted and should be made aware of specific instances where a person with unmet need does not appear to be eligible.

There are no other age, income or other criteria.

The criteria remain unchanged from the onset of the program.

They are consistent and no variation is allowed. There is no fixed period for admission.

Entry is not weighted according to intensity of care. There is, however, a review of each case; and this can result in a termination of service if need is not evident.

The program has an established review procedure (Document 20). There are two kinds of reviews:

1. Individual Case reviews are ongoing, according to a centrally established criteria set out in the attached. Each case must be reviewed at least every three months. This can be a total or partial reassessment, as the care plan required. They normally include a personal visit with the client, contact with family members and with the care providers.

2. Caseload reviews. This is a review of the overall management of program delivery, focussing on one or more program components. They focus on compliance with assessment/reassessment; eligibility, care planning and implementation, case co-ordination and resource utilization.

Rejection figures are reported in the annual report.

For March 1981 they were:

Admitted		Rejected					
781		Home Care not required	Person/ family refused	Admit to hosp	Home not suitable	Deceased	Other
	Rural	9	0	0	2	0	4
	Urban	44	4	6	0	4	8
	TOTAL	53	4	6	2	4	12

Grand TOTAL: 81
Percentage: 9.6%

There is some feeling centrally, that regions under-report rejections.

V. Service Utilization

Service utilization figures are reported in the accompanying documents.

There is in general no shortage of non-professional service providers. No study has been done of the shortage of professional staff. It is essentially a geographic problem.

Changes in recruiting techniques include stronger training and supervision; and more stringent initial assessments. At least one written response from references is required now. Special attention is given to the local recruitment and training of homemakers (Documents 21, 22 &23).

Staff training is done in the course of the case review process mentioned above.

Initial staff training is done by case co-ordinators and standards officers. There is a trend to more formal standards of care now.

Training materials include St. John's Ambulance materials, the Red River College (Winnipeg) Health Aide course. A care homemaker module is also being developed.

APPENDIX D

SASKATCHEWAN DISTRICT HOME CARE PROGRAM

I OBJECTIVES

"The main objective of providing home care services is to preserve and promote independence and self-care." This is done by providing services in the home to those who "would otherwise be forced to move from their own homes to institutional settings to receive assistance with activities of daily living and nursing care."[1]

This main objective can be more concretely discussed in terms of five operational objectives developed at the time the program began:

1. To provide four primary services in each home care district including nursing, homemaking, meals and home maintenance.

2. To assure that each of the 45 home care districts provides coverage, that is, to assure that all citizens have access to the primary home care services.

3. To assure that minimum standards of service provisioning are met.

4. To integrate the large number of pre-existing fragmented home care services into a unified system of home care delivery.

5. To provide district home care boards with a large measure of local autonomy, so that they may decide which services are most needed in their district and provide these in the intensity needed to those who need them most, subject to budgetary and primary service constraints.

These objectives are not measured except by crude figures, such as the number of boards providing service (21 out of 45). The program also does not operate in the area under the jurisdiction of the Department of Northern Saskatchewan.

The impetus for the program was both additive and substitutive. The program was conceived to provide the primary care services where they were not previously available, that is, to even out the availability of services in the province and fill a notable gap in the health care continuum. At the same time, however, the program was conceived as a deterrent to institutional care and a means for making early discharge from institutions a possibility.

Whether the program has achieved its substitutive effect is unknown. It is likely that its substitutive impact is limited by the lack of additional services, most notably rehabilitative therapies and transportation. Trans-

portation is the more critical of the two deficiencies and many districts have taken extra-governmental action to remedy this problem.

The program addresses all Saskatchewan residents who would otherwise go into a care-providing institution. Primarily, this means the elderly, and to a lesser extent, the disabled. It is worth noting that this province has the highest proportion of elderly in Canada. Due to a large influx of single males after World War II, the province also has the most balanced ratio of males and females among its elderly. Also significant for program delivery is the fact that only one-third of the provincial population is urban.

Prior to this Home Care Program (HCP) services were delivered in a "patchwork" manner, if at all, by a variety of voluntary agencies and local HCPs. Estimates indicate that about 130 social service and 19 health agencies were involved. As a result of the number of pre-existing services, priority has been given to establishing HCP where no comparable service exists at all. Integration of local programs, though an intention of the program, is seen as a gradual process with no tremendous urgency.

II PROGRAM STRUCTURE

1. Services

Four types of service are offered on a mandatory basis in the HCP. These include nursing, homemaker, meal service and home maintenance. These services are defined more clearly in Exhibit II - 1.

Optional services can be offered if the district budget can afford them. The optional services include social work, occupational therapy, physical therapy, nutrition counselling, chiropody and laundry service. While not included in the official policy manual, transportation services are offered in many districts -- often financed through some medium other than the HCP. Transportation has often been identified as an essential service, especially for those requiring special transport aid.

An additional HC service offered throughout the province is psychiatric HC. This service is viewed as a deterrent to institutional admissions, particularly appropriate for crisis intervention. Unlike most HC, only 20% of its clients are elderly. In addition, the psychiatric HC program is funded through direct grants from the Department of Health, a result of program creation by an Order-in-Council.

Admission to the psychiatric HCP is solely by medical referral. Regular HC, however, operates on a social entry basis with patients

referred by health care professionals, social workers, family or self-nomination.

2. Staff

The types of staff used for each mandatory service are described in Exhibit II-1. Education, training requirements and services for each type of staff are also described there. Work experience requirements for nurses do not strictly follow the two years experience requirement, and nursing supervisors may well be diploma R.N.s rather than B.Sc.N's.

Requirements for providers of optional services have not been clearly specified. It is understood, however, that rehabilitation services will be provided by a physical therapist (P.T.) or occupational therapist (O.T.) as appropriate. The shortage of P.T.s and O.T.s in the province makes it unlikely that rehabilitative services can be made mandatory.

Volunteers are used mainly for sitting and "meals-on-wheels". On occasion, they may also be available for home maintenance. The participation of volunteers is thought to have dropped slightly since introduction of HC. It has been suggested, in particular, that senior citizens groups could play a larger part. In general, when volunteer services decline, it is attributed to replacement of volunteers with paid workers in order to better assure the dependability of required services.

3. Administration

The program is based on the notion of local autonomy. A recent study indicated , however, that autonomy has not been characteristic of operations. Indications are that central office will probably accede to local requests and loosen the reins of control.

Local boards will have the authority to admit people to the program, select staff and provide services. Subject to budgetary constraints and mandatory services, they will have the choice of adding optional services to their program after the first year. They will also decide on the range of allowable service intensity and duration. They will also be free to modify eligibility requirements in order to assure that those with the greatest need have first access to services.

Despite this decision-making authority, there are urban-rural service differences. In particular, where optional services were available prior to home care, they have been continued. With few exceptions, this means that optional services are more readily available in cities.

In terms of administrative reporting, local authorities submit each month a budgetary statement and a copy of each client assessment summary or discharge. There is some intention to compile statistics from this information, but this has not been done to date.

EXHIBIT

Summary of home care services

Service	Nursing Service	Homemaker Service (ONGOING)			Meal Service	Home Maintenance (ONE-TIME)		
Type		Personal care	Home management	Attendant		Household tasks	Home maintenance	Home adaptation
Scope	Treatments examples – Dressings Injections Teaching self-care Supervision of other providers > EMPHASIS ON TEACHING AND EPISODIC TREATMENT	Activities of daily living bathing grooming dressing feeding toilet transfer Care of bed-bound examples – turning back-rubs routine skin care Activation examples – Physical exercise Activity – mobility Routine foot and nail care Maintaining medical regimens	Menu planning Budgeting Banking Meal preparation Care of children And may include Cleaning Laundry Ironing Mending Shopping Errands Changing beds	Sitting with client who cannot be left alone	Meals-on-wheels Wheels-to-meals	Snow shovelling Yardwork Changing storm windows Heavy seasonal cleaning And may include Cleaning Laundry Ironing Mending Shopping Errands Changing beds	Minor repairs Minor painting Others, which may require some special skill	Renovations necessary for independent mobility examples – Widening doorways Building ramps Installation of Saskatchewan Aids to Independent Living Program Equipment Safety devices
Provider	Registered nurse	Homemaker nursing assistant	Homemaker	Any qualified person > MAINLY VOLUNTEERS	Institution/ restaurant/ individuals/ activity centre > MAINLY VOLUNTEERS	Any qualified person	Any qualified person	Any qualified person
Training for provider	Diploma in nursing – two years experience (option)	Nursing assistant course/ Homemaker course And on-the-job training by nurse	Homemaker course	Volunteer training or Homemaker course	Homemaker course nutrition component	Appropriate to the task		
Supervisor	District nursing coordinator or Agency nursing supervisor	Homemaker supervisor	Homemaker supervisor	Homemaker supervisor	Homemaker supervisor or Meal service supervisor or Agency meals supervisor	Home maintenance supervisor		
Training for supervisor	Bachelor of Science Degree in nursing (4) Public health nurse – three years of experience	Homemaker course experience preferred in nursing	Homemaker course experience preferred	Homemaker course experience preferred	Homemaker course experience preferred	At the discretion of the district home services coordinator		

Exhibit II-1

4. Budget

The home care budget in each district is composed of three parts:

- A fixed administration grant of $25,000.
- A per capita grant of $12.30 which may eventually be weighted to compensate for the proportion of the population over 65.
- Fees collected from clients for services received.

Municipalities make no formal contribution, although gifts of equipment or provision of supplementary services are not uncommon.

Budget deficits have been known to occur, particularly when there is an effort to keep pre-existing services (now optional) going, rather than abandoning people. This may be remedied with help from central office in the form of financial advice, or if deemed justifiable, a supplementary per capita grant.

III SERVICE ISSUES

1. Related services

Prior to the creation of the current HCP, some 130 social service and 19 health related home care programs were operating across the province. At present, few of these have been amalgamated. This is due to a policy priority for providing care where not available before amalgamating services already available.

Parallel programs exist for a number of services related to, but not included in the Home Care Program. These include visiting psychiatric and medical social workers, as well as several psychiatric nursing home care programs. One could also consider visiting nurses (The Victorian Order of Nurses - V.O.N.) a parallel program, as well as day hospital arrangements for physio-and occupational therapy.

Each of these parallel services is free to set its own eligibility requirements. It is not known how much movement between programs exists and liaison between programs is not structured.

2. Contracting of services

Each district home care board is free to choose the amount of service they wish to contract. Where services pre-date the HPC, contracting tends to be heavier than where services are new. For example, Saskatoon has a large number of home care services available through a number of agencies; thus the HCP anticipates contracting about three-quarters of its first year services.

IV ELIGIBILITY

1. Assessment

The initial program assessment is done by non-professionals who have received a two-day training program in patient assessment. Assessment is based on the results of a standardized assessment form developed at Duke University. The form, OARS, is 32 pages long. Under ideal conditions, that is, an experienced interviewer and a lucid and not too talkative interviewee, the assessment takes about an hour. Under most circumstances, however, it takes considerably longer.

OARS is used to assess all program applicants, regardless of the type or intensity of service they request. It assesses the patient on five dimensions: social resources, economic resources, mental health, physical health, and activities of daily living. A cumulative impairment score can also be generated. These ratings are the basis used for designing a package of services to meet the clients needs.

Once a service package has been designed, an assessment committee is expected to review and approve the package. This committee is ideally composed of the district manager, the district nursing coordinator and the Home Care Program Coordinator. A medical consultant is available if needed.

Assessments and service packages are reviewed continuously on an internal basis and a more formal quarterly review is expected.

One problem which should be mentioned about this system is the OARS form. While it is a highly reliable instrument which leads to good agreement on service packages, it is also extraordinarily time-consuming. Additionally, many people feel it absurd to spend two hours assessing someone who wants their walk shovelled. As a result, most districts have taken matters into their own hands and have developed some shortened version of the tool on an ad hoc basis. This shortened tool which used from place to place, is probably the most common basis for designing service packages.

2. Eligibility criteria

Eligibility is based on an assessed inability to remain at home, along with a lack of family resources to provide the needed assistance.[2] This assumes that the client is a Saskatchewan resident, who is covered under the Saskatchewan Health Services Plan. Physician referral is not necessary for program entry.

Perhaps the biggest limitation on entry is that all of the services you need to prevent institutionalization must be available. Since

rehabilitative therapies and transportation are not mandatory, these pose a significant problem to many potential clients. The problem is most acute in rural areas.

Bearing this problem in mind, there are two kinds of eligibility to consider. Eligibility for service and eligibility for financial assistance. The basic criteria for service eligibility have already been stated. These can be modified locally, however, in order to provide the "most needed" services to those who need them most. In short, the board of the HCP can design the plan which best meets the districts needs -- some balance between assessed needs and HCP policy. Quite often, this type of plan will involve limiting service. Thus people may be found ineligible for home care because:

- They require too much care (local definition of limit).
- There is not enough family support for them in their home.
- The services are available elsewhere (hence not offered).
- The cost of keeping them at home is more than in an institution.

While few people are turned down completely, many people will receive less service than they desire. This may be due to service limits or an unwillingness to pay for extra services. In any case, treatment plans and services are considered flexible, with reviews scheduled quarterly in most cases.

As for financial eligibility, this is assessed at the initial assessment interview. Those receiving aid (85%) from the Saskatchewan Assistance Plan (SAP), Family Income Plan (FIP), Saskatchewan Income Plan (SIP), Guaranteed Income Supplement (Federal), or Saskatchewan Social Services pay up to $30 per month for all services. The remaining 15% of program clients pay $30 of the first $60 expenses each month plus a percentage of the cost of remaining service costs. The percentage is about 1% for each $5 of net monthly income. These fees were initially set up to recover administrative costs of the program. Given the 85% with only nominal change, it is suspected that the bookeeping costs of this fee system may exceed its collected fees.

In addition, local boards negotiate fees for services. Where costs are high locally, the program tends to attract mainly those receiving some assistance. This creates some inequities in who tends to receive service.

D. SERVICE UTILIZATION

1. Service

Total admissions to Home Care Programs in 1979-80 were 7,711. The total budget for that year was about $6.4 million. The number of admissions for 1980-81 is unknown, but the budget has increased to $10.3 million.

It is believed that the majority of services provided are support services. Those nursing services provided tend to be geared toward teaching. Personal care services while supervised by a nurse, are often given by a homemaker. The light demand for nursing is characteristic, despite the fact that nursing care is free and support services must be paid for.

Nursing service is usually given on prescription from the local family physician. In a few cases, the medical consultant (M.D.) to the HCP prescribes treatment. In general, if extensive nursing care is required, it tends to be given by the family with support from home care.

2. Staffing

Staffing categories and their requirements are presented in Exhibit 1. There are no statistics available on the number of personnel of each type.

Most staff are contracted for services on "as-needed" basis. Only the manager and the secretary are full-time for most HCP's. In a few places the district nursing and home care coordinators are also full-time, but these tend to be the larger programs.

Volunteer services are used primarily for sitting, surveillance and meals-on-wheels. Volunteer services are not charged back to the client, but the cost of their services (meals) are charged.

There is no real staffing problem for mandatory services. Most staff are solicited by personal contact rather than advertising. Turnover is generally low, although homemakers sometimes take higher paying jobs from nursing homes.

Among the optional services there is a real demand for physiotherapy. Provision of this service has been critically limited by the lack of trained P.T.s.

3. Training

Training of staff is proceeding in a variety of ways. Homemakers are now trained by the Red Cross and St. John's Ambulance. Community

college programs are generally offered on an in-service basis at the request of the community. The Homemaker program has met with some objections from the Saskatchewan Registered Nurses Association (SRNA) in that it teaches some skills which have traditionally fallen within the nurses role.

VI OTHER COMMENTS

A short collection of comments and or recommendations which don't neatly fit elswhere.

- Transportation is one of the most sought after services. It is not formally offered in the program but it is often "fiddled". Can be used for doctor's visits, trips to activity centres, daily living needs or use of day hospital program. Generally suggested as available on contract basis from local taxis or scheduled basis from special purpose vehicles.

- Too much central control of petty details despite philosphy of autonomy. This is leading to lower regional morale and falsification of data to get around the "meddling central office". Central office reins are "too tight" and "too slow to respond".

- HCP can pose a threat in rural areas. By displacing people from hospital beds they threaten the existence of small local hospitals. In turn, the loss of the hospital may well mean the loss of the community's doctor. This could be circumvented via transport from home care and use of day hospital plans.

- Current fundingon a mix of administrative grants and per capita funding results in deficits in large districts and those with services prior to home care.

- As a general rule, simplicity of criteria is preferable to complicated criteria based on cost-efficiency. Complicated criteria have been found to have their own costs and lead to inconsistencies and local "fiddling" to get around these.

- The fees collected for service probably yield a net loss after administrative costs. They affect too few people to be worthwhile. Either a flat admission fee, monthly fee, or no fee at all is preferable -- but note that many feel they must pay something -- they don't "take charity".

- Conflict between medical and social entry can best be resolved by using entry from either side with services provided by a unified service delivery agency placed between social services and health.

- Psychiatric home services are an alternative worth consideration in program expansion. Quite successful in Saskatchewan.

- Elderly require a single entity which they can call to refer them to any and all services. An assessment agent capable of referring them to any service. This is especially needed for crisis intervention.

- Fees for service tend to be a deterrent to teaching "self-help" services. Client doesn't understand the services leading to independence that well and is resigned to current incapacity, thus refuses to pay for this type of service.

- There is a danger of adding rather than substituting for services if assessors do not have a sufficiently broad notion of "normal" limits to capability or environment. A tendency to underestimate the client and their setting.

- Most likely area for savings is crisis intervention. Treatment of acute conditions (broken hip, death of spouse, etc.) which if not treated quickly and fully can lead to institutionalization.

REFERENCES

Portions of this report were excerpted from:

Home Care Status Review Team, Home Care Status Review -- Summary. (March 24, 1981).

Saskatchewan Social Services, Home Care Policy and Procedures Manual.

APPENDIX E

BRITISH COLUMBIA
HOME CARE PROGRAMS

A. BACKGROUND

Home care services in B.C. are provided mainly by the Ministry of Health through its Long Term Care and Home Care programs. The Ministry of Human Resources also provides homemaker services to families "in crisis" and to retarded adults living in the community. The questionnaire responses are organized such that for each question, the answers for each program are indicated as follows:

Long Term Care -	LTC
Home Care -	HC
Family Support Homemakers -	MHR

Importantly, LTC includes care provided in residential facilities along with care provided in the home. It is not always possible at the present time to split the information for home services from that for residential (facilities) services.

I OBJECTIVES

LTC

Objectives of the Long-Term Care Program (1978)

1. The Long-Term Care Program (1978) is designed to meet the individual needs of those who, because of health related problems, are unable to live independently. Its aim is to promote the highest level of independence possible for those assessed as being in need of this care, providing, where and when indicated, the support necessary to allow the beneficiaries to live as normal an existence in their own community as their infirmities permit.

2. The Long-Term Care provided by the Program will be readily accessible to all who have need for its services, and will, where possible, be provided in the beneficiary's own community. These services will include a home support service and, where nedessary and available, institutional care in an approved community care facility licensed to provide personal or intermediate levels of care; or, the beneficiary of the Program may be admitted to an extended care hospital.

HC

The main objectives of the Home Care Program

1. To provide comprehensive health care services to ill or handicapped persons whose physical, social and emotional needs can be met safely and adequately in a home environment.

2. To provide preventive, therapeutic, rehabilitative and supportive health services to a patient.

3. To coordinate the multiple services being provided to the patient.

4. To encourage personal and family involvement in the planning and provision of care for the patient.

5. To help maintain and support the family unit and family relationships.

6. To reduce the length of acute hospital stay through early discharge to Home Care.

7. To prevent unnecessary admission of patients to acute hospitals or other facilities, e.g. terminal patients.

MHR

Family Support Homemakers provides temporary support and relief to families under stress. The goal of intervention is maintenance of a family's routine during a period of crisis. This service may also be used to sustain the independence of a retarded adult living in the community. (Document One)

Subpoints

The degree of achievement of objectives is not currently being measured.

The objectives are not stated in legislation

The objectives were developed before the programs began.

The Ministry of Health is presently conducting a study of the current operations of the program in the Local Health Districts (L.H.D.'s). A contract researcher has been hired to do this work and is examining many issues also covered by this study.

a) These programs were intended to substitute for existing services (LTC and HC) and have not to date provided services not previously available.

b) LTD were essentially conceived to consolidate existing services to the elderly.

The MHR program is targetted at families in short-term crisis and retarded adults living in the community.

Subpoints

Particular patient types targetted by the Health programs.

LTC: chronic, long term (over 19 years of age)

HC: acute, and early-discharge post-partum

II. PROGRAM STRUCTURE

A. SERVICES OFFERED

LTC

a) Home support services are those services that are required to permit the beneficiary to live independently at home. These persons will have health related problems that do not necessitate care in an acute care hospital, but without support may require placement in a personal or intermediate care facility, or an extended care hospital.

b) These services are primarily homemaking and housekeeping services, home nursing care and auxiliary services such as meals-on-wheels. Visits by a social worker, a nurse, or a representative of other health related disciplines may also be programmed into the regimen of these beneficiaries.

c) Home support services are not intended to relieve persons and families of any function which they can and should provide for themselves or the member of their family who is entitled to benefits under the Program. These services will primarily employ personnel to furnish home help services, in order that the beneficiary may have the physical and emotional comforts necessary to live independently at home, in a safe environment.

HC

The Home Care Program has two categories of patients - Category I, Non-Hospital Replacement and Category II, Hospital Replacement. Services offered to patients in both categories are the same and only the financing shows some variation. Patients may be transferred from one category to the other with no break or change in service.

Category I - Non-Hospital Replacement

Patients in this category are those who require at least one professional service, e.g. nursing, physiotherapy, occupational therapy, etc. in addition to physician care and who may also require other services, e.g. homemaker, equipment, etc. but who do not require acute hospitalization.

They do however require professional care in order to remain safely in their homes, to receive necessary treatment, to be rehabilitated to the greatest degree possible or to maintain their existing level of health. A large number of persons with chronic conditions are included in this category.

Category II - Hospital Replacement

Patients in this category are those discharged early from an acute hospital to the Home Care Program or those placed on Home Care in lieu of acute care hospitalization. They remain in this category as long as they are "replacing acute hospital days" and during this time receive all services required at no cost to themselves, e.g. nursing, physiotherapy, medication, supplies, homemaker, etc. All costs are paid by Community Health Programs (Ministry of Health). The majority of these patients are acutely ill, require at least one professional service, e.g. nursing or physiotherapy and may require extensive frequent services over a short period of time.

MHR

Child care and household management services are provided.

The hospital replacement services of HC are available in only approximately 85% of the province. The remaining Health Services are available province-wide (in general).

Who decides whether a potential client should receive home care services?

LTC: The assessors are usually nurses or social workers. Physicians are only involved on a consultative basis, and are often the referral source.

HC: Referrals are assessed by the Home Care Administrator, liaison nurse, public health nurse or supervising nurse.

MHR: Social workers assess clients' needs for homemaker support.

Types of personnel used to provide services:

LTC: Assessment - provided by RN's and SW's
Homemaking - provided by homemaker course graduates
Home maintenance - provided by volunteers and non-professionals
Limited personal care - provided by homemakers

HC:

1. Nursing - provided by experienced registered nurses on the Home Care Program staff of the health district. The Home Care Administrator and the Assistant Administrator are experienced public health nurses.

2. Physiotherapy - provided by qualified community physiotherapists on the Home Care Program staff of the health district. This service is not yet available in all areas of the province.

3. Occupational Therapy - provided by qualified community occupational therapists on the Home Care Program staff. This service is not yet available in all areas of the province.

4. Homemakers - provided by the local Homemaker Agency as arranged for by the Home Care Administrator.

5. Meals-on-Wheels - provided by the local meals-on-wheels agency or through other special arrangements.

6. Medication and medical supplies - provided by local hospital and drug store or through health district or the provincial pharmacy as arranged by local Home Care Administrator.

7. Equipment - provided through Red Cross Loan Service or other local supplier on referral from Home Care .

8. Social work - provided by local Ministry of Human Resources staff on referral from Home Care Administrator.

9. Laboratory and x-ray service - supplied by local hospital or other facility as arranged by Home Care Administrator.

10. Transportation - provided by voluntary agencies, family, friends or taxi or ambulance as arranged by Home Care Administrator.

11. Nutritionist or dietician - supplied by health district nutritionist, hospital dietician or other resource as arranged by Home Care Administrator.

12. Other - may include referral to other resources e.g. mental health centre, clergymen, geriatric counsellor, Long Term Care staff, etc.

MHR: Homemaking support - provided by trained homemakers.

e) Both the Ministry of Health and MHR programs are regionally administered. LTC and HC services are thought to be generally uniform across the province although this issue is currently under study.

f) Information reported from local units to central agency.

LTC: Age, Sex, Marital status, Address, Contact person (sample form appended)

HC: Age, Sex, Admission Dates, Diagnosis, Care provided and Costs (sample form appended)

MHR:

g) Current MIS status

LTC: revised system now being installed - old system inadequate, incomplete, slow

HC: revised system to be installed in 1982 - old system as per LTC

MHR:

h) Budgeting - regulated by the local administrator

i) Municipalities do not provide funding for home care programs

III SERVICE ISSUES

a) Home care services in B.C. are provided by Health, Human Resources and some private (commercial) homemaking and home nursing agencies.

b) Extent of use of contracted services

LTC: 90% contracted (approximately)

HC: Health Ministry staff do all work between 8 a.m. and 10 p.m. At other times, users pay for services provided.

MHR: Almost all homemaking services are provided by non-profit agencies.

IV Eligibility

LTC

A. Purpose

1. The purpose of this chapter is to provide a standard method of processing the applications for long term care in the Province.

2. To achieve this aim, it is imperative that the Long-Term Care Administrator's office be organized to reflect its role in the Program, namely - the control point for long term care provided in the community it serves.

B. Source of Referrals

1. Referrals to the Program may come from any of the following sources:

   a. the applicant
   b. the family of the applicant
   c. friends of the applicant
   d. an acute or rehabilitation hospital
   e. a long term care facility not participating in the program
   f. a physician
   g. a professional in the community (nurse, social worker, mental health worker)
   h. others (concerned neighbour, landlord, etc.)

C. Methods of Referrals

1. The methods used to refer applicants to the Long-Term Care Administrator will be as diverse as their source and will be in the form of:

   a. phone calls
   b. letters
   c. personal visits, etc.

D. Disposal of Referrals

1. The Long-Term Care Administrator will receive many applications for entry into the Program. Many will require no further action except an official acknowledgement to the effect that the enquiry, letter, etc. has been received and noted to file; others will require a decision as to whether further action i.e. visit to applicant is required. The remainder of the referrals will be valid and require a thorough investigation and a decision made as to the level and type of care required.

2. It is imperative therefore, to the systematic disposal of all referrals that the health units procedures and registry reflect this responsibility. (See Chapter XVII-Requirements for Local Registries)

E. Control of Referrals

1. In order that applications for entry into the Program are processed as expeditiously as possible, it is recommended that each Health Unit provide:

   a. A register of applications to record in chronological order all referrals to the Program and the external disposition of these referrals i.e. Long-Term Care Administrator - assessor No. 1 etc.
   b. An alphabetical registry wherein all applications, letters, memos to file, etc. may be recorded for ready reference, and
   c. Such other files as the Long-Term Care Administrator may deem necessary to control this function and the assessment procedures inherent to the Program.

2. The requirements for local registries are detailed in Chapter XVII.

F. The Assessment Procedure

1. The assessment procedure comprises seven basic steps; they are:

   a. referral to the Long-Term Care Office;
   b. recordiny of referral (see E.1.a. above);
   c. Visit by designated assessor;
   d. recommendation by designated assessor;
   e. reviewed decision by Assessment Team where appropriate;
   f. post assessment discussion with the applicant/family/sponsor and the appropriate care service or facility; and
   g. placement in the home, residential care facility or extended care hospital (See Chapter III - Post Placement Control)

2. Procedures to be followed at each step are:

a. Referral step - all applications, whether by telephone, personal visit or applicant/family, letter, will be recorded in the Unit Registry and referred immediately to the appropriate assessor by the clerk/receptionist.

b. Intake step - the designated assessor will register the application, make an evaluation of the urgency of the situation and make a decision whether or not a visit is required. In a crisis situation an immediate visit will be made. The assessor will inform the applicant's physician as a matter of routine.

c. Visit to applicant/family - the designated assessor with the assistance of other team members where indicated will visit the applicant as soon as possible after the intake step is completed to :

(1) explain the Long-Term Care Program (including charges) to the applicant;
(2) discuss with the applicant/family their current situation and any alternatives;
(3) complete the assessment form (at Annex "A" to this Chapter) where appropriate and determine whether there are financial concerns as related to paying for home support, residential or hospital services.

d. Recommendations of assessors - the designated assessor(s) will keep one copy of the assessment form, sending the other two copies with recommendations to the Long-Term Care Administrator of the unit for review and inclusion to the agenda of the next assessment team meeting.

e. Assessment team -

(1) Composition - the assessment team should comprise:
(a) the Administrator as chairman
(b) a Public Health nurse
(c) a social worker
(d) a mental health worker when required (see Chapter IX) and
(e) a Homemaker Society Supervisor

In addition to this core, the administrator may augment the committee as appropriate to the needs of the applicant with:

(f) a physio therapist
(g) an occupational therapist

(h) a representative of the hospital/facility wherein the applicant may be placed
(i) the family physician
(j) a representative of the local voluntary health agency and/or
(k) a representative of the District Office, Ministry of Human Resources

(2) Meetings - the assessment team(s) should meet weekly as a rule; however some regions may have to adopt modified schedules due to distance involved, number of referrals, etc.

(3) Decisions - on completion of its deliveration, the assessment team will record its decision as follows:

(a) no service required
(b) level of care required
(c) implementation of home support service
(d) placement on the waiting list of the designated care facility, hospital, or mental health boarding home (See Chapter IX)

Where there is a likelihood of delay in the placement of an application into a residential or extended care institution the assessment team will also approve measures of interim management. In a crisis situation this could include:

(e) immediate home support (See Chapter VII Annex K)
(f) temporary institutional placement

f. Post assessment discussion with applicant/family/sponsor
The Long-Term Care Administrator or designated representative will visit the applicant to explain the committee's decisions and the action being taken to place the applicant into the Program.

g. Placement in the home, facility, hospital or Mental Health boarding home -

When placed into the program, the Health Unit's (Long-Term Care) responsibility for the applicant will continue and will require that a bring forward system be set up in the unit to ensure review of beneficiaries in accordance with Chapter III D (Post Placement Control)

HC

Patients are selected for admission on the basis of an individual assessment by the Home Care Administrator or her staff. Criteria used are as follows:

- Referral by physician.
- Patient lives within the area served by the Program.
- Patient must require at least one professional service other than medical e.g. nursing, physiotherapy, occupational therapy.
- Patient and his family must be willing to accept the services of the Program.
- Needs of the patient can be adequately and safely met through Home Care Program services.
- Home is suitable for Home Care.
- Family or home situation is such that safe patient care can be maintained between visits of the home care team.
- Cost of care in an extended basis must not be greater than that in a "Personal Care Home".
- For Category II (Hospital Replacement) for admission the patient must be replacing "acute hospital days" and his stay in the category will approximate the "hospital days replaced".

A request for service may originate from the patient, his family, the patient's physician, Long Term Care Program, local hospital or other community agencies.

The Home Care Administrator, liaison nurse, public health nurse, or the supervising nurse assesses the referral to determine need, and whether the patient can be adequately and safely cared for on the Home Care Program. This information may be obtained in a variety of ways: physician interview, patient and family interview, home visit, etc.

Where the patient's physician has not made the referral but the nurse on assessment determines that immediate nursing care is needed, she may provide the care without a physician's order. If continuing care is required, the patient or family must contact his physician to obtain a referral and specific orders for Home Care. If, for any reason, the patient or family are not able to do this, the nurse should contact the physician directly.

MHR

In general

- the criteria have only been altered to 'correct' for inflation
- the criteria are consistent across the province
- eligibility is not time-limited for LTC but is for HC (for acute medical conditions)
- eligibility for LTC is supposed to be reassessed every 6 months. Until recently, however, this was not consistently done due to workload on assessors.
- no information is available on rejected applicants.

V. Service Utilization

LTC: breakdown only available by age and sex for home program (Dec 1980) caseload

Age:	54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90-94	95-99	100+
M	450	223	379	651	1099	1446	1244	970	426	100	22
F	1035	651	1165	2165	3057	3510	3401	2279	897	197	36

HC: breakdown only available by age and care type (hospital replacement or non-hospital replacement) for January 1981 admissions

Age:	0-19	20-64	65+	
Non hospital replacement	73	622	1370	(figures include
Hospital replacement	199	810	435	multiple admissions)

MHR: approximately 850 families per month received homemaker services at a cost in 1980 of $3,726,340.

Subpoints:

- definitions of service units and costs are currently under study in the Ministry of Health
- service may be limited in remote areas of the province due to staffing difficulties and travel time
- staff turnover rates are not known for home care
- some B.C. vocational colleges offer programs leading to homemaker certificates.

POOR

QUALITY

ORIGINAL